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cover story

The Psychiatrist Goes Into the Community

Until recently, most psychiatrists worked in their own private offices or in institutions. People with problems had to come to them—or be sent to them—for help, and many people never reached them. With the advent of the concept of community mental health, more and more psychiatrists and other mental health workers are going out into the community, especially into disadvantaged neighborhoods. The result may be that more people in trouble will be helped and even that serious mental disorders will be prevented.

mental health digest

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Mental Health Consultation With a Paramilitary Youth Program

David M. Port

Paramilitary youth organizations, known as cadet corps, are popular in poverty-stricken, urban areas. Sometimes referred to as the "poor man's Boy Scouts," these groups use a military climate to attract youngsters into "character-building" programs. This report describes my experience with a cadet corps which I shall fictitiously call the South Bronx Church Cadet Corps (SBCCC). The SBCCC is one of 20 units in a 2,000 member, citywide organization. Unit meetings, held in churches throughout the school year, are replaced in the summer by a centrally conducted Summer Academy. The director invited me to observe classes and other activities. I visited so regularly that I was able to come and go unannounced—though not unnoticed. Since the Academy's staff has the same personnel as the units during the school year, the visits served as an opportunity to prepare my entrée into the unit level.

Another step was to get in touch with the Rev. Mr. T., minister of the church at which the SBCCC meets. Known as the unit's spiritual adviser, he doesn't supervise it and rarely comes to meetings. He sees his responsibility as providing a meeting place and giving a modest contribution to the corps fund. Once a year the cadets are invited to participate in a religious service at the chapel.

According to Mr. T., the youngsters attracted to the corps are the "rougher element." In contrast to a Boy Scout troop that uses his church's facilities, the cadets are sometimes rowdy and destructive. The scouts tend to come from Puerto Rican, higher-income, "middle-class-oriented" families; the cadets are predominantly black, from poorer, one-parent homes. The cadets' parents are rarely members of the congregation.

At the SBCCC opening meeting, staff was surprised that I kept my word since most professionals, even if enthusiastic about the Summer Academy, never appeared at local meetings. Although suspicious and guarded, staff were pleased at my interest and receptive to the idea of my attendance. I also reminded staff of my willingness to offer mental health services, the form of which could be collaboratively developed.

For several months I sat through meetings and watched. I had informal chats with the unit commander and his staff. Friendly relationships developed as we got to know one another—and as they realized I was not a government "investigator." In addition to making general observations, I tried to determine how I might provide consultation.

The commander, an energetic man in his mid-twenties, attended college for a year before taking a full-time job with the organization. His three assistants, about the same age, completed high school and work part time for the organization while engaged in full-time skilled outside occupations. Twelve teenagers serve as "officers"; they volunteer or receive small stipends that vary with age, rank, merit, and time commit-

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ment. Although regularly assigned to the SBCCC unit, staff and officers work at other units at different times of the week. About 70 boys, age 7 to 13 years, comprise the "cadets." All cadets and about half of the leaders live in the immediate vicinity. Most leaders have "grown up in the cadets." Their dedication reflects in part the sense of purpose and belonging that seems to be provided by such involvement.

A meeting begins with a number of cadets showing up before the 4:00 p.m. starting time. Until "general formation," they engage in free play or basketball. Once the whistle is sounded, they line up according to military form. An officer exchanges salutes with the unit commander, then leads the group in the "Pledge of Allegiance," "Cadet Pledge," and a prayer, all conducted with pomp and ceremony. There are announcements and comments by the commander or a staff assistant. Then the cadets divide, according to age, into four "companies." The program is carried out in these smaller groups, each led by teenage officers. Another "general formation" precedes the 6:00 p.m. dismissal.

Content of the program varies. About half of the time is spent in drilling. Early in the season the focus is on rudiments; as the year progresses, the groups move on to exhibition drilling. An annual review, in which all units compete, serves as a goal. The remaining time is divided between recreation (fencing, basketball, ground games, karate) and instruction (dress, hygiene, manners, knot tying, Morse code). The program is enriched by weekend trips to an out-of-town camp, tournaments, and visits to headquarters for special events (carnival, drum and bugle corps exhibitions, movies).

Leadership is mainly in the hands of the teenage officers. The unit commander outlines a curriculum for the coming month; at the beginning of each meeting, officers hand in a written description of plans. The adult staff step in to help only if asked to do so or "if we see something going wrong."

Comments by staff support the impression that the helping function enhances the teenager's socialization process. One member pointed out a 16-year-old, now proud and spirited, whom he had personally rescued "from the streets" when the youth was vacillating between "joining the junkies or the extremists." For many officers cadet leadership is the first experience to provide a sense of importance.

The staff provides assistance if help is needed. They go to court to get teenagers out of jail, encourage completion of high school, go to out-of-town colleges to seek scholarships, and provide informal tutoring for high school subjects.

The cadets are the center of attention. Expectations vary according to the youngster's age, but he is supposed to "behave in a manner befitting a cadet," attend meetings groomed and dressed in uniform or dark slacks with white shirt and tie, pay dues, help recruit other cadets, and obey orders of an officer or staff member without "kidding around." The degree to which the rules are enforced varies from one officer to another, depending on personality style and convictions.

I noted incidents suggesting need for consultation that would help the cadet leadership to think through the

mental health attitudes relevant to such goals as the development of character, pride, and self-esteem. An officer "bawls out" cadets who did show up because many others are absent that day. A youth is made to stand in the corner for 30 minutes for laughing during a drill. Several outsiders, members of an extremist group, drop by and are engaged in an authoritarian discussion concerning their presumed nonbelief in God; they do not return the following week. In rare situations a cadet may be sent home, generally when his "misbehavior" causes the leader to become exasperated, but he is allowed to return the next week, if he so chooses.

I concluded that consultative efforts would be most worthwhile if directed toward the teenage officers. This was based on several considerations: They were the primary change agents. Their youth and status as "trainees" suggested greater flexibility and lower resistance to change than would be expected at higher levels. They constituted the future staff and community leaders. They might benefit personally while improving their competence as helpers.

When the unit commander requested help in "educating" the officers, I offered to show how a training workshop could be conducted. Over the next two months, discussions with the commander determined the goals, content, and form of the workshop. Opinions of staff were solicited; all decisions were left to the commander. Eventually our goal was established: To increase the teenage officer's awareness of his role as a socializing agent. "Leadership Training" would be the goal and title of the workshop.

Other decisions were: The commander would attend the workshop as an observer; even though I would lead the meeting, choice of topics would be left to the group; rules regarding formality of address and respect for rank would be relaxed. The commander agreed to arrange for refreshments and to present "certificates" to officers who attended all meetings. Following each session, he and I would hold an informal discussion.

At the first workshop, the commander set an informal tone and gave assurance about freedom and confidentiality of discussion. He then turned the group over to me. At subsequent meetings he would call the group to order before asking me to begin the discussion. My minutes of the preceding session were read aloud at the start of each meeting to reinforce the learning experience.

The group chose two topics: "Discipline" and "Sex." My approach was to encourage them to bring up illustrations of difficulties or questions that came up in their work with the cadets. In this manner I was able to accomplish my goal of sensitizing the officers to their importance as change agents. Use of empathic skills was stressed as a way to understand behavior and to plan for handling a given situation.

When one officer brought up the case of a boy who refused to undress for showers, I asked: "What might make a 9-year-old child behave in this way?" A portion of the discussion that ensued:

Member A: "Oh, he just wants special attention."

Member B: "Yeh, just trying to be a wise guy."

Leader: "Certainly, one possibility is a desire for attention. What other reasons could there be?"

Member C: "Could be a 'psycho' or something."

Leader: "True, in an extreme case I guess we could be dealing with a very dis-

turbed child; but I wonder if there aren't more normal, everyday kinds of reasons."

Member D (probably with the fewest emotional conflicts): "Well, when I was a kid, I was sometimes worried that my underwear was torn or dirty . . . embarrassing . . . so made up an excuse not to undress." (Laughter with general agreement.)

Member E: "Another thing is if the kid's afraid his penis is too small . . . not enough of a man . . . afraid the other kids will make fun. . . ."

The group decided that it might sometimes be best to excuse a youngster or allow him to shower in shorts and then have a private chat with him.

Despite a focus on helping younger children, the emotion with which the group involved themselves suggested intense, vicarious identification. This was obvious regarding homosexuality, masturbation, and premarital sexuality. At times, emotional involvement would lead to statements of a personal nature; so long as the anxiety level did not seem excessive, such expressions were not discouraged. My stance involving sex was to imply a relativity of behavior standards coupled with emphasis on accurate information, including knowledge of the consequences of one's activities.

The participants' receptivity was enthusiastic. Not only were they eager to learn, but they seemed appreciative of the "free discussion" style. Attendance increased as the workshop progressed. Officers from other units came to sit in on the discussions. During the last meeting, participants completed unsigned questionnaires in which they rated the workshop and made suggestions. Ratings were favorable, and all officers suggested that training be offered throughout the year.

The commander was also enthusiastic. He indicated that he had learned a great deal from the workshop—in addition to the postsession discussions. He felt better equipped to handle behavior problems and to advise the officers concerning sex. An incidental, though possibly significant, consequence is a rekindling of his interest in completing college.

Although verification will require controlled studies, my impressions point to the value of developing mental health consultations with paramilitary youth programs. The collaborative nature deserves comment. My entrée was in the role of learner, and the offer to provide a training workshop evolved within the context of repaying the organization. Although not quite a "fee-for-service" model, this reciprocity helped minimize status and autonomy conflicts.

Additional demonstration workshops might encourage staff to assume leadership of such exercises, in which case the consultant could withdraw to a more behind-the-scenes, supervisory role. Case consultation might be developed to provide direct services for troubled children. Intervention might be attempted with parent groups. Perhaps with additional training in mental health skills (along with evaluation and quality control), cadet corps might serve treatment functions for selected young people. Ultimately, contracts might be developed through which mental health consultation could be exchanged for "treatment" services provided by cadet corps organizations.

Mental Health in the Job Corps: An Exploration of the Role of the Mental Health Worker in Programs of Education and Training

LEE B. MACHT, WILLIAM J. BICKNELL, DONALD J. SCHERL, and ELIZABETH OZAWA

The Job Corps is the national residential training program for 14–21-year-old youngsters from poverty backgrounds. This report brings together the experience and thinking at a two-day mental health colloquium sponsored by the Job Corps in 1967.

During its first year and a half, the mental health program in the Job Corps had little direction. Job Corps policy now directs that mental health services not only include direct care, but programs of consultation and education, staff training in mental health areas, and crisis intervention. Although it was not set up as a preventive psychiatric institution many mental health workers view the Corps as having significance from this point of view.

For the worker interested in children and youth, the problems of disadvantaged youngsters and how to "reach" them have been challenging. The question of how to translate clinical knowledge and training into programs of national significance has been a critical and unanswered one. What contribution can the clinician make? What is the role of the mental health worker? The colloquium sought to explore these questions.

The mental health workers expressed their goals in terms of the individual, although frequently these goals could only be achieved in ways other than direct work with the individual. The Corps member was characterized as a person "in crisis, caught between identities, insecure, and unsure of himself." The worker felt this could be attributed to adolescence, to the fact that the Corps member comes from a background of poverty and instability, and to the fact that in the Job Corps center he is far from home, in a strange environment. The Job Corps, according to this view, has the overall goal of providing a stable, positive identity to sustain and support the enrollee while he is learning new skills, forming a new concept of himself, and developing new values.

Corps member recruitment, selection, and assignment—The Job Corps process begins with recruitment and selection. The consensus was that the Job Corps has the responsibility to work with and attempt to rehabilitate all youngsters from low-income backgrounds who need intensive educational, vocational, and psychosocial assistance, in a residential setting, in order to become employable. The mental health worker is often responsible for deciding whether there are facilities other than the Job Corps to deal with youngsters with problems too severe for adjustment to Job Corps life. Assignment to centers distant from the youngster's home may cause difficulties. Another issue is related to the 16-year-old Corps member. His presence has meant that activities and privileges have had to be scaled to his level of development. These youths have problems if they leave the Corps while aged 16, since they are too young to enlist in the

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armed services and cannot be hired no matter how skilled they are.

Behavior, identity, and community considerations—Some participants felt that the identity of "Job Corps members" may be a negative one as far as society and the Corps member's peers are concerned. The community in which the center is located was thought to have considerable impact on the Corps members. The surrounding community is often white, middleclass, and unfamiliar with problems of poverty or race. If the community develops hostility and fear, incidents are likely to occur. The incidents, and the repercussions from within the center and its staff, will do much to solidify the ideas of an already bitter Corps member about his place and function in American society. The mental health worker may be in a position to stimulate, foster, and work toward increased positive interaction between Job Corps Centers and local communities.

Readjustment—The Job Corps experience often proves to be a meaningful one, and graduation poses a number of readjustment difficulties. Transitional programs have been developed to assist in readjustment to the home community or relocation to a new community. This is comparable to a halfway house and can ease the transition between the center and an independent way of life. The Corps member who leaves the center, whether by dropping out, termination, or graduation, is expected to find his own way—often back into the environment from which he entered the Job Corps. The colloquium posed the issue of whether benefits derived from the youngster's stay at the center might be negated by loss of contact with the center and the values it represents. It was a matter of controversy whether gains in the Job Corps could or could not stand up after return home.

Job Corps as an institution—Many difficulties arise from characteristics of the Job Corps: the agency is young, it is unique in this country, and it has a rapid turnover of staff and Corps members. The Job Corps center tends to be crisis-oriented and sensitive to pressure, whatever the source. Finally, the staff who leave often do not orient or train their replacements so that experience and competence are constantly being drained off.

Mental health worker-center staff relationship—The participants felt that their work with staff was the most important aspect of their Job Corps work, and the yardstick by which their success or failure could be measured. Several reported that the staff treated them as figureheads. When one psychiatrist arrived in response to a crisis call, he found that staff had dealt with the problem, and wanted only his sanction for their decision. At another center, staff expected the mental health worker to "rubber stamp" approval of discharges.

Even for the professional who is well accepted, the staff present difficulties in consultation. Resident advisors and dormitory counselors are closest to the Corps members, yet are the most difficult group to work with. The mental health worker threatens this group more than others, although they call most for his consultative assistance. In his efforts not to threaten, he may try to send cases back to the resident advisors and counselors, only to find that this makes it more difficult for the Corps member. Occa-

sionally, resident advisors give up efforts to be more than custodians, maintaining that a "quiet and tidy dorm is a happy dorm."

Another problem was conflict between the administrative branch and the counseling branch regarding the Corps members with serious behavior problems. The administrative branch usually favored discharge, while the counselors were willing to try to keep the Corps member. The mental health workers found themselves in the middle.

The mental health worker—Often a mental health worker will feel ill at ease when his allegiance is claimed by two opposing groups. He is asked to assume roles and perform functions which may seem foreign to him. The relationship with the center staff may be different from what he is used to. A colleague relationship with the staff member is most desirable, but at the time the mental health worker must balance attitudes of deference and authority, often with the same person. Another issue centered around isolation. Many centers are far from urban areas, and quite inaccessible. From the point of view of professional concerns, some workers felt that theirs were "lonely voices in the wilderness."

The contract—The more care taken over negotiating a contract, the better the chances of coming to grips with the significant issues of mental health at the center. The contract should be negotiated with the center director himself, as well as with the medical director. It should consider the amount of time that the mental health worker can devote to the center, and what procedures are to be followed if a crisis occurs when he is not there. The consultant should not undertake treatment of staff, as this would jeopardize the colleague relationship. The contract should include an understanding of the kinds of services that the mental health worker will provide. It should be kept open for renegotiation at any point.

Time considerations and priorities—One central fact of mental health work is that professional time is limited. If the mental health professional is a regular member of the staff, he may be in a better position than the part-time consultant, but even so he will find that it is difficult to establish priorities. The dilemma of how best to be useful—(direct) treatment or (indirect) consultation and education—is serious. Time must be allotted to both activities. The balance between these different functions and the way in which they are woven together to form a comprehensive mental health program is a critical issue.

Technical aspects of work with Corps members—Psychotherapy with Corps members poses technical problems. The environment from which they come does not encourage introspection, analysis, or verbalization of fears and emotions. The Corps member's attention span is short. His perception of the difference between himself and the mental health worker—color, economic status, age, authority position—may make it difficult for him to communicate.

Crisis intervention—Crisis intervention is part of the professional's work at the center. When a crisis occurs, he must ensure that there is a "helping other" available to the individual, be it counselor, advisor, teacher, M.D., or himself. As an individual therapist he may have sessions with the Corps member alone. As a mental health consultant and educator, he should teach the staff the basics of crisis intervention.

Staff training and education—Often the education and training needed by the staff of a center begin at fundamental levels. It requires skill in human relations to get across the intent and content of a training program, and to create the most propitious conditions for learning. For example, the staff may turn to the mental health worker for assistance with sex education. Although perhaps not his special expertise, this is an area where his skills can be brought to bear, in designing a sex education course and helping to train the staff to give it, or in conducting it himself.

The assumptions regarding a mental health professional in a Job Corps center vary with the expectations of the staff and with the way in which he presents and conducts himself. Staff may expect him to lay bare the deepest problems of the people he works with, submitting all to gratuitous and public analysis. He may be expected to be a witch doctor who will cast or break spells with the power of learned words. He may be expected to be a specialist, whose rightful and only concern should go no further than "the sick kids." He may be expected to be a teacher who will deal out the well-kept secrets of working with people and problems to those who can ingratiate themselves with him. He may be seen as intruder, threat, or messiah. These expectations reflect the contradictory images of the mental health professions held by many.

Often the mental health worker can be an exclusive confidante to the Corps members by virtue of his distance from the rest of the staff, and can be trusted with confidences that might result in shame or termination if revealed to anyone else. The mental health worker may be the first adult who is not a policeman, welfare worker, or truant officer to give the Corps member a few hours of undivided, nonpunitive attention. This attention alone provides a salutary effect.

The staff can derive support from the mental health worker's presence. One of his functions is that of role model for the staff in terms of his capacity for warm, giving, but professional contact with the youngsters. They see in him the prototype of a helping person, and he can reinforce whatever training or education he has provided by the sanction his presence and actions afford.

"It's our problem" was a statement made at the end of the last session. It might serve as the keynote for the whole colloquium. For in essence, the mental health worker's real function in a Job Corps center is that of a problem solver. The development of the Job Corps as a functional, therapeutic program is the mental health worker's problem. In the Job Corps center, and in other similar programs, he can find a challenge that may be unequaled in contemporary mental health work.

Design of Catchment Areas for Community Mental Health Services

Jack Zusman

The catchment area is a key concept of community psychiatry. Equivalents of catchment areas—police precincts, school districts, fire districts, health districts—have been used for many years.

Establishment of catchment areas can have a powerful effect on mental health professionals and agencies. Where previously an agency was free to close its doors to applicants when it was working at capacity or could reject an "undesirable patient," it is no longer able to do this. Even if patients are sent to the State hospital, in most cases this provides the agency only a temporary respite. Once partially recovered, the patient will return.

The increase in the burden on community mental health services and the loss of the opportunity to pass the buck forces a change in orientation. While an administrator's first impulse may be to request an increase in budget and staff, these are usually not forthcoming. The next moves must be to increase professional effectiveness, to decrease per patient treatment cost, and to search for new ways of delivering service.

Catchment areas also foster continuity of care. Once a patient begins treatment with an agency, his treatment continues with that agency regardless of changes in the patient's diagnosis, conditions, or age. Only a change in residence would interrupt treatment.

Catchment area responsibility makes it impractical to provide only one sort of care. Patients must be assured that whatever the severity or course of illness, treatment will be available. Catchment area service agencies must be generalists. Presumably, the generalists cannot be as skillful in treating particular syndromes as specialist agencies. With use of catchment areas, there may be a decrease in quality of care and a broadened range of skills.

An agency trying to provide enough services may have to compromise its standards by using less highly trained people. There are not enough mental health professionals (and never likely to be enough) to meet the demand. Previously some agencies could maintain high standards by limiting admissions. At the same time, other agencies had to accept all applicants regardless of limited capacity. Standards of care in these "agencies of last resort" were low. Catchment areas ought to result in a leveling of quality among all agencies.

When it is easier to obtain service, persons with low motivation will apply for treatment. Proponents of community mental health feel this situation is good. Those with poor motivation are likely to drop out of treatment early or if they do continue not to make maximum use of the treatment opportunity. Difficulties in obtaining treatment have served as a screen to eliminate those with poor motivation. It remains to be seen whether motivation for treatment is related to benefit.

Catchment area planners sometimes disregard traditional ties between agencies and particular citizens

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who support the agencies, e.g., many agencies and hospitals have been established under religious sponsorship or with particular ethnic or geographic relationships. In assigning catchment areas, it is often not feasible to take these ties into account. A loss of financial support can result when catchment area residents get priority over the traditional group. Ties of private practitioners to a general hospital can be disturbed when a hospital develops a catchmented mental health service unit. The practitioners expect preferential treatment for their patients. The catchment concept requires that priority be given to residents of the area rather than to any group of patients. The result can be resentment by the practitioners and a loss to the hospital of their services.

Catchment areas can simplify research and evaluation of mental health services. When all services are directed toward a specified population, it is possible to study the impact on that population. Per capita costs can be compared among different kinds of social services and among mental health centers serving different populations. Effectiveness of prevention and rehabilitation programs can be measured. Epidemiologic research is simplified.

Finally, catchment areas foster close and stable interagency relationships. Two different kinds of agencies serving the same population will work together over a long period. It becomes advantageous for the agencies to establish regular contacts. Staff time can be shared, mental health consultation is facilitated, and joint projects can be undertaken.

There is no formula for dividing a region into catchment areas. Although many parts of the country have been divided into catchment areas, the number of places where areas are being served by operating mental health centers is small. On the basis of theory, however, and a small amount of experience, it is possible to list major elements which must be taken into account when designing catchment areas:

Natural neighborhoods—People develop loyalty to a neighborhood. Neighbors tend to tell one another about service, and, when community organization is a part of mental health work, organization will be facilitated. In city and suburban areas, public transportation has to be a major consideration. In rural areas, the pattern of roads must be given consideration.

Coincidence with other service districts—Most public service agencies are using geographic districts. It is important that catchment areas coincide with these districts. This simplifies comparisons of utilization of services, encourages effective liaison among agencies, and makes community organization and mental health consultation easier.

Heterogeneity of population—It is important that a mental health service unit serve a population cross section. Clients of public health and social welfare units have often been segregated by race or social class because of geography, financial requirements, or local law. In addition, central city areas tend to have residents with serious mental health problems. Professionals working exclusively with these populations may become discouraged or overwhelmed. It is desirable to include persons from other socioeconomic groups with less serious problems.

Expected service demands—Since certain groups have greater needs

than others, it may be necessary to have catchments of different sizes. Agencies serving high-demand areas should have smaller populations than those serving lower demand areas.

Existence of other service facilities—Mental health services must depend upon hospitals, vocational rehabilitation facilities, welfare departments, visiting nurse agencies, and such ancillary facilities as halfway houses and boarding homes. Where to locate a catchment area must in part depend upon proximity of other agencies.

Community interest and support for mental health services—Community mental health services depend on cooperation and support from the community. These cannot arise completely spontaneously, but must be organized by formal or informal organizations. Areas vary in their willingness to use and support community mental health services. It is a mistake to assume that in an area where theoretically there should be a high demand for service this necessarily will occur.

Existing patterns of utilization—Patients tend to develop loyalties to particular service institutions. Patients who move away may continue to come to the neighborhood to make use of the hospital or physician. Establishment of a new unit may not be well received if this requires disruption of established loyalties.

Existing and projected patterns of population movement—Mental health center planning often takes place years in advance of the opening of a new facility. Catchment area size and composition should be estimated on the basis of projections for the time when the center will be in operation.

Existing and future State hospital districts—Most community mental health service units will continue to relate to a State hospital. Relationships between local and State hospital personnel develop more easily when catchment areas are designed so that each community mental health unit has to relate only to one State hospital unit.

Geographic districts of related service facilities—Relationships and administration are eased when facilities such as sheltered workshops, mental retardation programs, alcoholism treatment units, and narcotic addiction treatment units have catchment areas related to those of community mental health units. Most special service units will serve more than one community mental health center. The ideal arrangement is for the special facility areas to be made up of several community mental health center areas.

Census tract boundaries—Important population statistics are kept on the basis of census tracts. For planning, comparison, and evaluation, it is helpful if each catchment area is made up of complete census tracts.

Likelihood of development of service—Because of the shortage of personnel and funds, many parts of the United States will not have community mental health units for years. It might be wiser to catchment only those areas which will receive services in the near future.

Presence of special population groups—Groups with special eligibility for mental health services, e.g., members of industrial unions with mental health benefits can change the pattern of utilization of services. Presence of such groups should influence the size of catchment areas.

Presence of general hospitals—The prevailing thought seems to be that

mental health centers should be associated with general hospitals. Catchment areas must be designed wherever possible to contain a general hospital.

Political considerations—When mental health service units are supported by government and where it is the responsibility of government to designate catchment areas, weight must be given to political considerations. These may include alignment of catchment areas with legislative districts or inclusion of a particular group in a catchment area in order to win legislative support for the mental health program.

Optimum population size—Although 200,000 population has been set by Federal regulations as the maximum for a catchment area, the most important consideration is how many people will use the service. Where the utilization is high, a catchment area can be smaller than 200,000. Where utilization is low, the catchment area might well be larger.

Once a community determines to organize services along catchment areas, several obstacles must be overcome. Many communities are not easily divided into 200,000 size areas. This is so in counties where the population is not divisible into multiples of 200,000 and where there is a single hospital with a tradition of providing services for the entire population. New facilities will become a part of a single service system under these conditions. Many localities do not have the resources to recruit staff to establish new units in each catchment area. The only hope is to build upon the single facility which exists.

The obvious means of strengthening facilities is to obtain Federal funds. Yet, Federal funds require division into catchment areas. Counties often reorganize in one way on paper, while maintaining the old county-wide organization or divide one facility into two services—a catchment area service and a general community service. This can lead to second-class care for most local residents—those not in the catchment area.

Once a community is divided into catchment areas, there will be persons who are unhappy. Some will feel their particular interests have not been given enough weight. These complaints seem to be essentially political and political answers must be developed. The problem is one of bending a compromise to meet the needs of as many people as possible while not completely meeting the needs of any one group. If catchment boundaries have been properly done, enough persons will feel that they are satisfied or at least that they would be dissatisfied with any alternative. They are willing to apply political pressure to support the original proposal. If their political pressure is not sufficient, a new set of catchment area boundaries must be negotiated, which will attract the necessary political support.

A serious problem can arise when existing facilities are tied into catchment areas and become part of community mental health centers. To be eligible for Federal funds, they must give priority to residents of the catchment area. Even without Federal support, this is the sensible way to organize community mental health services. Yet, such an organization requires facilities to give secondary priority to nonresidents who may have devoted years of support and to whom the agency feels it owes a good deal. Staff physicians who are accustomed to admitting their patients to a particu-

lar hospital and who have given service to the hospital will find that their patients no longer get top priority. This causes unhappiness and may leave some facilities without essential services or funds as physicians and contributors withdraw support. A hospital may be caught in the dilemma of having to choose between Federal funds or voluntary donations and physicians' services. Most hospitals cannot afford to do without any of these. One solution is a campaign to develop public support and understanding for organization of community mental health services and, at the same time, intensive effort to develop service units in all other local catchment areas. Local residents may then not be able to go to their favorite mental health service unit, but they do have another unit for treatment.

A final problem is the transitional period from the time the first local community mental health center opens its doors to the time when the last catchment area has a mental health center service. During this time, either mental health centers designed to serve a single area must serve more than one or some existing facility must continue to operate. The solution seems to be to plan for temporary services with manageable overloading of all local units.

Many assumptions fundamental to the decision to use catchment areas and to community psychiatry are untested. Some seem to be untestable and are in the realm of moral values or ethical judgments. Even for the convinced community psychiatrist, catchment areas present some disadvantages and problems.

Some Troubles With Social Science: A Plea for Research on Research

Brian N. Lewis

For all the money spent on researching social problems, the problems seem as intractable as ever. The time has come to look at current research practices, in order to see what research can and cannot do.

Social science can be defined as any systematic inquiry which seeks to obtain information by *communicative interaction* with its subject matter. Whereas physical science relies on *casual interaction* with its subject matter, social science relies on interpersonal communication.

Defined in this way, social science includes anthropology, sociology, political and economic science, social psychology, individual psychology, and so on. And it subsumes smaller areas (criminology, managerial studies, teaching and learning, psychotherapy, etc.). It is appropriate to have an all-embracing conception of social science, because the branches and subbranches all run up against the same methodological problems. The question of what is wrong with social science can be construed as the question of what goes wrong when human beings try to learn about, and understand one another.

The next section lists eight sources of bias and difficulty in social research. The list is not complete, but it gives a fair idea of the ground that needs to be covered.

Some Major Sources of Bias

Bias due to experimenter's behavior—There are many ways in which an experimenter (E) can unknowingly bias the behavior of his subjects. Depending on the way in which E approaches and interacts with his subject (S), he may induce expectations and attitudes that will influence S's behavior.

Bias due to social context—The circumstances or "social context" can induce distinctive forms of bias. For example, replies to a questionnaire may differ according to whether E interrogates S in a laboratory setting, on S's doorstep, or in S's living room. Data obtained under competitive conditions are different from data obtained under relaxed conditions. Findings obtained in one social context are not necessarily generalizable to different social contexts.

Bias due to subject's personality characteristics—Most S's like to give a particular kind of impression when placed in test-like situations. To exhibit this kind of response bias, all S needs to know is that he is under observation. The critical issue is whether response bias can be minimized and/or *measured*—so that its effects can be allowed for in the analysis and interpretation.

Bias due to method of observation—If S does not know he is being watched, it should be possible to obtain a more accurate record of his behavior. Unfortunately, unobtrusive observations are difficult. Under certain conditions, E might be able to observe S and also manipulate S's environment. But this is even more difficult and it poses ethical problems.

Bias due to the verification mentality—Humans do not like to be

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wrong. The desire to be right can be described as the verification mentality—the mentality which induces E to prove only what he wants to prove, and which protects him from noticing ways in which he might be mistaken. A discussion of verification mentality might have been included as a special form of bias due to E's behavior. The point about the verification mentality is that it can influence all of E's research behavior from the very outset of his research project. It is not uncommon for researchers to conceive a piece of research as demonstration of what they "already know."

Bias due to the uncritical use of other people's data—In social science, experimenters often rely on other people's data. An inquiry into juvenile delinquency might use school reports, health records, I.Q. and personality tests (administered by other people), and testimony from parents, relatives, law-enforcement officers, and other witnesses. E is using "preprocessed" data. There is no way of estimating the bias which inheres in such data. There is a more subtle way in which other people's data can influence the "findings." This occurs whenever E discovers a significant correlation which can be explained (post hoc) in several ways. To avoid follow-up experiments, E might decide that one explanation is "obviously" the right one, and select from the literature reports that support his views.

With the advent of microfilm, computers, and the like, it is now possible to set up data banks in the social sciences and to retrieve information, cheaply and at short notice. There is every reason to expect an increase in the practice of using other people's data. There are special circumstances in which this might prove worthwhile, but the practice is a potentially dangerous one.

Bias due to inadequacies of experimental design—The above sections have been concerned with inadequate design. There is a more restricted sense in which "experimental design" refers to matters which are the concern of statisticians—adequacy of pilot experiments, problems of sampling, problems of measurement, selection and running of appropriate statistical tests, and final interpretation and reporting of results.

Additional sources of bias—Bias due to *selective publication practices* arises from the fact that "significant" results are considered more newsworthy than nonsignificant. A bias due to *short-term funding* policy is convenient for some purposes. It enables students to join a project at its inception, and to leave with a Ph.D. thesis at the end. But it has drawbacks. For example, it induces research directors to rush prematurely into print so that they can justify the appeal for additional funds. There is bias due to *allocation of funds*. There are many other complaints that could be levelled against funding practices. Most agencies prefer "good-risks"—people with university affiliations working along accepted lines who will publish liberally, even if their findings are not worth publishing. There is also no distinction between sponsoring projects and sponsoring brains. There are problems in the sociology of knowledge concerning the basis on which scarce research funds get allocated. It is clear that a great deal of research money ends up in the wrong hands. The problem is whether it is possible for funding agencies to be wiser before the event.

The Need for Constructive Suggestions

Persons who do social research get cross with methodologists who complain about the quality of their work. There are good grounds for irritation. Most methodologists criticize other people without doing any empirical work of their own. And they often prescribe standards which are impossible to achieve.

Every researcher knows that social research involves compromise. Time and money do not allow elaborately controlled experiments. Demands of a rigorous methodology may be incompatible with the need to treat one's subjects in humane and considerate ways.

Methodologists will not win a sympathetic hearing until they start expressing their views in the form of practical guides. If a methodologist thinks that a research technique causes bias, he should say how biasing the technique is. If the magnitude varies under different conditions, he should say what these conditions are. He should specify the conditions (if any) under which the bias is usually small enough to be ignored.

The antagonism between researchers and methodologists is unfortunate. The insights that methodologists have are reasonable and valid. What is wanted is a massive tidying-up operation in which the insights and issues are presented in a clear and meaningful perspective.

Methodologists frequently worry about the generality and validity of reported findings. If the findings are based on answers to a questionnaire, they wonder whether the findings are "an artifact" of the questionnaire. The implication is that, if the questions had been worked differently, the results might have been completely different. The important word is "completely." Nobody would be surprised if slight changes in the questionnaire produced slight changes in response patterns. What is irksome is the suggestion that small changes might completely overthrow or demolish the case he is trying to make.

Methodologists worry about measurement. In the analysis of attitude scales, they might worry about the numerical properties of the scales used. In the case of "content analysis," they might worry about the distortion that occurs when verbal responses are mapped into a small set of a priori response categories.

What can be done to dispel these kinds of misgivings? Well, it helps to have *big* differences and/or *big* correlations. Throughout social science, there is no substitute for big results.

This is only a partial answer. Ideally, the worries about artifacts of questionnaires should be met by constructing several questionnaires, or by showing that the questions used have generic properties—that they are typical of a whole class of similar questions.

With regard to the measurement problems there is a need to demonstrate invariance. What is wanted is a set of theorems which will specify the conditions under which statistical results remain constant over a range of plausible measurement procedures. In the absence of such theorems, it is open to the researcher to try out different measurement procedures to see whether he repeatedly comes up with the same answers. Once again it helps to have big differences.

As an illustration of the constructive steps that need to be taken, the next sections indicate areas to which methodologists might direct their attention. There is no claim of com-

pleteness, and there may be other areas that deserve greater priority.

The need for impossibility proofs—Even in pure mathematics not everything can be proved. Social science might benefit from a similar demonstration. It might be useful to consider what kinds of proposition can be proved and under what conditions. At present, many people seem to have optimistic views of what is achievable. The assumption is, given enough effort of the right kind, any problems can be solved. This is a rash assumption, although it may be bad for business to say so.

The need for different methodologies—In setting up the conventional "well-designed experiment" and letting it run, the experimenter is in a position in which it is difficult for the results of his experiment to be affected by any subsequent insights he might have. If he has any significant insight during the experiment, he is obliged to reserve it for later, although he can use it as a talking point in his final report, or he can set up another "well-designed experiment" in which the same thing could happen again. A more flexible methodology would be useful. Other methodologies try to allow for changes that can occur in human subjects (due to unwanted adaptation and learning effects), while the experiment is actually in progress. These suggestions and procedures are exploratory, and their implications have still to be worked out.

The need to look beyond the significant correlation—Most social research stops as soon as significant correlations or differences have been found. It is easy to obtain significant correlations, especially if large samples are used. In the literature, inferences are often based on correlations as low as .2 or .3. Correlations of this size imply that a rather weak association exists throughout the sample or that a strong association exists within some part of the sample, and a weaker, or even negative association exists within other parts of the sample.

In both cases, more work needs to be done. There is need to look for new variables that might correlate more highly with variables of interest to the researcher, and to examine the overall sample for evidence of subsamples which fail to show the overall association. In both cases, there are grounds for doubting the usefulness and generality of isolated significant correlations.

The need for self-correcting social science—It is said that the American Behaviorist, Hull, remarked that he reserved the right to change his postulates every morning before breakfast. Underlying this remark was his belief that his "hypothetico-deductive method" was self-correcting. Although Hull was hopelessly optimistic about the self-correcting nature of his activities, his attempts at self-correction were laudable.

Cost effective analysis—Any systematic examination of social science must take account of economic considerations. Certain kinds of social inquiry might be hardly worth attempting, if resources are too limited. Other kinds might be wasteful, even if resources were limitless. There is a break-even point beyond which expenditure of more time, money, and effort is subject to the law of diminishing returns. It is important to set up criteria for deciding what these break-even points are.

Direct action research—Translating research findings into social action is a two-stage process: discovery of

significant new findings and conversion of findings into action. Direct action research is appealing because it tries to save resources by running the two stages concurrently. For example, nobody knows how the "school of the future" will be organized. Instead of researching the matter in an abstract way, some schools (containing the latest audiovisual aids, computers, and the like) might be set up to see what problems actually occur. This sort of direct action research could be an expensive failure. But there is much to be said for the direct action method, if it is handled with care and sensitivity.

Values and ethics—There is a widespread belief that social research is value-free. The whole problem needs closer investigation—if only to alert the researcher to the social consequences of his actions. The interests of social science might be better served if researchers were to indicate where they stand in the conflict of values that they are studying. It is of interest to note that there are value problems which masquerade as empirical problems. They arise, for example, whenever some government agency or foundation wants to investigate (say) the deterrent effect of Capital Punishment or feasibility of Subscription Radio. Such matters can not be resolved by empirical facts alone.

Research as a Means to Understanding

Social science is, in the best hermeneutic tradition, an understanding activity. Man is not an acosmic spirit, capable of comprehending the universe of being in a single glance. He is physically and informationally in the world that he is trying to make sense of. Researchers should be modest about the interpretations they offer. In the absence of procedures that can locate the causes of complex social phenomena, it is up to every researcher to keep a weather-eye open for promising ideas and insights which might illuminate, supplement, and even replace his own. This calls for continuous interaction with other interested parties—and humility which enables the researcher to learn and profit from ideas different from his own.

But humility and good intentions are not enough. There is an urgent need for stronger methods of fact-finding, law-finding, and theory formation. It is possible that nothing much can be done to accelerate man's understanding of complex social problems, but it is worth the effort to see what can be done. And the first candidate for investigation must be the social research process itself.

A Modified Concept of Consciousness

R. W. Sperry

In studies involving surgical section of the cerebral commissures, we have been confronted with questions concerning the quality and distribution of conscious awareness in the bisected brain. The hemispheres appear to be independently and simultaneously conscious, each oblivious of the mental experiences of the opposite hemisphere and of the incompleteness of its own awareness. Many problems are raised in regard to the seeming unity of conscious experience in the normal and bisected condition and the relation of conscious unity to the neural process. How should we conceive the unifying role of the corpus callosum and the nature of the information it carries between the two domains of consciousness? Do the conscious qualities extend from grey matter into the corpus callosum? What is the nature of the interface between the conscious and unconscious processes?

One thing to come out of these concerns has been a modified concept of the nature of mind and its relation to brain activity.

The supreme importance of this problem for human values, as well as scientific matters, prompts us to search ahead of the evidence for any possible new insight. Even a partial solution that would enable us to decide between broad and general alternatives—like whether consciousness is cosmic or individual, mortal or immortal, in possession of free will or subject to causal determinism, etc.—could have profound ideological implications. In any search for meaning, identity, ultimate goals and values, or new ideologies, the nature of mind and its relation to physical reality becomes central and basic.

Most behavioral scientists have little use for consciousness. It is difficult to see any place in the material brain process for the likes of conscious experience. Most investigators resist any suggestion that the causal sequence of electro-physico-chemical events in the brain could be influenced by conscious or mental forces. It is the working man's faith in the neurosciences that a complete objective explanation of brain function is possible without reference to subjective mental phenomena. Whatever the stuff of consciousness, it is agreed that it does not interact causally on the brain's electrophysiology or its biochemistry.

My interpretation of consciousness takes issue with this prevailing view. I postulate that the conscious phenomena of subjective experience do interact on the brain process exerting an active causal influence. Consciousness is conceived to have a directive role in determining the flow pattern of cerebral excitation. It has been the custom in brain research to dispense with consciousness as an "inner aspect" of the brain process, or some kind of "epiphenomenon" or "paraphenomenon" or other impotent by-product, or even to regard it as merely an artifact of semantics, a pseudoproblem.

My interpretation would make consciousness an integral part of the brain process itself and an essential constituent of the action. Consciousness is put to work. On these terms subjective mental phenomena can no

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longer be ignored, and mind and consciousness become reinstated into the domain of science from which they have been excluded since the advent of behaviorism and dialectic materialism. I shall briefly outline the salient features of the hypothesis and the reasoning behind the foregoing statements.

Conscious awareness is interpreted to be a dynamic emergent property of cerebral excitation. As such, conscious experience becomes inseparably tied to the material brain process with all its structural and physiological constraints. At the same time the conscious properties of brain excitation are conceived to be something distinct and special in their own right. They are "different from and more than" the collected sum of the neurophysicochemical events out of which they are built.

Compared to the elemental physiological and molecular properties, the conscious properties of the brain process are more molar and holistic. Just as the holistic properties of the organism have causal effects that determine the course and fate of its constituent cells and molecules, so the conscious properties of cerebral activity have analogous causal effects in brain function that control subset events in the flow pattern of neural excitation. My proposal may be said to place mind over matter, but not as any disembodied or supernatural agent.

It is not meant to imply that the properties of consciousness intervene, interfere, or disrupt the physiology of brain cell activation. The accepted biophysical laws for the generation and transmission of nerve impulses, for example, are not violated. The electrophysiologist does not need to worry about this, provided that he restricts himself to analytic neurophysiology. He does need to be concerned, if he wishes to follow a sensory input to conscious levels and to explain how a sensation or a percept is produced, or how the subsequent volitional response is generated.

Although the mental properties in brain activity do not intervene in neuronal physiology, they do supervene. This comes about as a result of higher level cerebral interactions that involve integration between large processes and whole patterns of activity. In the dynamics of these interactions, the more molar conscious properties supersede the more elemental physio-chemical forces.

To put this another way—the individual nerve impulses and associated elemental excitatory events are obliged to operate within larger circuit-system configurations of which they are only a part. These larger entities have their own dynamics with their own qualities and properties. They interact causally with one another. It is the emergent dynamic properties of certain of these higher specialized cerebral processes that are interpreted to be the substance of consciousness. It would be helpful if one could illustrate this with a few fluoroscopy-like films of higher cerebral activity patterns. However, instrumentation in brain research remains inadequate to record pattern dynamics. About the only instrument by which one brain can plug into and read out directly the conscious experience of another brain is the corpus callosum.

The subjective mental phenomena are conceived to influence and to govern the flow of nerve impulse traffic by virtue of their encompassing emergent properties. Individual nerve impulses and other excitatory components are carried along or shunted this

way and that by the prevailing overall dynamics of the whole active process (just as drops of water are carried along by a local eddy in a stream or the way the molecules and atoms of a wheel are carried along when it rolls down hill, regardless of whether the individual molecules and atoms happen to like it or not). It also works the other way around, i.e., the conscious properties of cerebral patterns are dependent on the action of the component neural elements. A mutual interdependence is recognized between the sustaining physico-chemical processes and the enveloping conscious qualities. The neurophysiology controls the mental effects, and the mental properties control the neurophysiology. One should remember, however, that the conscious phenomena are in a position of "higher command."

This hypothesis represents a compromise between older extremes of mentalism and materialism. It is mentalistic in accepting mental forces that transcend the material elements in cerebral function. It is materialistic in denying that these mental forces can exist apart from the brain process of which they are a direct property. This "emergent interactionism" or "idealistic materialism" permits proponents of both extremes to retain some of their more important concepts.

Whereas the interpretations of consciousness as inner aspect, epiphenomenon, or semantic pseudoproblem have remained sterile, conceptually the emergent interaction scheme is potentially fruitful. It suggests new problems, possible approaches, and new leads. For example, the brain process must be able to detect and to react to the pattern properties of its own excitation. It must detect the overall qualities of different kinds and species of cerebral process and respond to these as entities. There exists considerable indirect evidence that the brain does in fact do exactly this. One may include here the extensive evidence on perception collected by the Gestalt school. My view rests on an extension of some of the same holistic principles extrapolated to cerebral physiology.

Among other implications is the conclusion that a full explanation of the brain process at the conscious level will not be possible solely in terms of biochemical and physiological data. Important as these data are for understanding cerebral activity, they fall short of providing an account of mental phenomena like sensations, percepts, ideas, images, illusions, feelings, etc. We need a further description and account of the higher order pattern activity in the cerebral process.

The foregoing points out the specific problem of determining the nature of the unifying forces that cause a pattern of excitatory events to function as an entity in brain dynamics. It emphasizes the need for new technology to record the pattern aspects of cerebral function which can only be extrapolated from indirect or highly particulate sampling procedures.

To determine how the more elemental physiological aspects of brain activity are used to build the emergent qualities of awareness becomes the central challenge. At present even the general principles by which cerebral circuits produce conscious effects remain obscure. Very possibly these will be understandable, in terms of advances in cerebral design superimposed on the background of an already elaborately evolved central

nervous system. There is reason to think that the organizational features of the neural circuitry for generating conscious awareness are genetic or inherent and are activated through the brain-stem arousal system, and once activated, become exquisitely responsive to changing sensory as well as centrally generated input.

This interpretation implies revision in traditional stimulus-response concepts of central nervous control. Any scheme in which sensory impulses are conceived to be routed through a central network system into a motor response becomes misleading. My view suggests the presence of ongoing central processes specifically organized for conscious awareness around the different sensory modalities. These central mechanisms have their own organization and dynamics that are determined centrally and autonomously. The sensory input becomes incorporated into the central process, altering the dynamics of the system and thereby its conscious properties. The initial train of sensory inflow is absorbed and transformed within the higher level central mechanism, and only indirectly through its perturbation of the holistic properties of the central process does the sensory input influence awareness or the volitional motor response. This view places greater emphasis on the central processes and their specialized organizational features that create out of neural excitation the higher order phenomena of mental experience.

The primary thesis implies something like the following: As we look around the room at different objects in various shapes, shades, and colors, the colors and shapes we experience, along with any associated smells and sounds, are not really out where they seem to be. Like hallucinations or the sensations from an amputated phantom limb, they are entirely inside the brain. The perceived colors and sounds, etc., exist within the brain not as epiphenomena, but as real properties of the brain process. When the brain adjusts to perceived colors and sounds, the adjustment is made not merely to an array of neural excitations correlated with the colors and sounds but to the colors and sounds themselves. Many uncertainties remain and the foregoing is only proposed on a tentative and speculative basis for its consideration alongside alternative theories for explaining mind and consciousness.

Conflict, Contract, Conscience, and Confession

O. Hobart Mowrer

Until recently, the assumptions concerning the nature and destiny of man were determined by belief in an anthropomorphic God and personal immortality. As life, under the sway of science and technology, has become comfortable and intelligible, belief in immortality has declined. Interest in secular psychology—which literally means the science or study of mind or "soul"—is growing at an unprecedented rate. The first scientific theories of man which have enjoyed acceptance in this century have proved to be inadequate; so the search goes on for a new synthesis of theory and practice which can give us a true science of man.

For many centuries Western man regarded himself as a special creation, a "Child of God." With the rise of Naturalism new theories came into prominence. Man is seen as the Product of Heredity and Environment. But the equation, Heredity × Environment = Man, has not proved satisfactory. The Individual Himself enters into the picture and helps form, or deform, himself. The contribution which the Individual Himself makes to his development is sometimes called the Third Force.

The Third Force posits free will, capacity for choice, self-direction, responsibility, creativity; for a long time these concepts seemed to be scientifically inadmissible. However, developments indicate that the philosophy of science and its technologies have reached a point at which this dilemma is no longer acute.

Another Third-Force orientation has arisen; in it the emphasis falls upon the premise that man is a *social* animal and that he prospers or perishes as a function of how well he manages to fulfill himself in this regard. I have been personally affiliated with a Third-Force psychology known as Integrity Theory or Integrity Training. Here the assumption is that personality difficulties arise when there is a discrepancy between a person's standards or interpersonal commitments and a person's actual behavior, performance, conduct.

Emphasis upon individual responsibility and man's sociality has come into prominence only within the last decade or two. But a quarter of a century earlier a similar position was developed by Adler in a conceptual scheme called Individual Psychology. Adler took account of the individuality of human beings by positing for each a unique life style, a "whole," and "indivisibility," of which the person himself is the principal architect; but at the same time man's essential sociality is acknowledged and dramatized by the German term, *Gemeinschaftsgefuehl*, which defies English translation.

Adler anticipated both aspects of contemporary Third-Force psychology. Man's manifest destiny is to find a useful, respected, beloved place for himself among other men. But man may exercise choice in regard to the route he takes to reach this destination. Indeed, he has a larger option before him: to seek the objective of maximal and creative involvement in the human enterprise, *or* rejection of the goal itself.

Let us imagine two prehistoric

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men competing for an object which they can barely touch by leaping into the air. One of them makes the other a proposition: "If you will let me climb on your shoulders, I can obtain the fruit, and I will then share it with you." Here a conflict has been resolved by a genuine *social contract.* Assuming that the man who gets the fruit is true to his word, both parties profit and are well satisfied—and thus disposed to resort to this type of cooperative problem-solving. Out of this interpersonal transaction has evolved the cooperative division of labor and specialization which provides the heart-beat of civilization.

Let us assume that the first man (A) does *not* "keep his word." There has been a breach of contract, cheating, unfaithfulness. What could primordial man do to redress such a wrong? One possibility is that B will come upon A unawares and inflict pain or death. B punishes A, and if A survives, he will be disposed to take his commitments more seriously. He will develop a conscience, which may first result in shame; but with refinement, will be capable of producing guilt. Shame occurs when an individual has broken an agreement and been caught in the transgression; guilt is the cognitive and emotional state following transgression, in the absence of external knowledge or detection of the act.

Guilt serves two social functions. One is that of preventing the occurrence of wrong behavior. There is now evidence that normal and so-called neurotic persons do not differ in their capacity to experience guilt after the performance of a proscribed act, but in their ability to exercise control over their behavior before its occurrence.

Freud popularized the theory that neurotic anxiety arises because of temptation, i.e., from the repression of "instincts" struggling unsuccessfully for conscious recognition and gratification. An alternative is that the anxiety experienced in psychopathological states arises because the afflicted individual has lacked the necessary "ego strength" to resist temptation and has performed a forbidden act, and then becomes guilt-ridden lest his concealed deviance and moral "inferiority" (guilt) be discovered. Persistent guilt is disconcerting and painful. One way of resolving such a state of affairs is for the transgressor to acknowledge the wrong and open the way for restitution and reconciliation of the estranged parties.

At least some instances of psychopathology have their inception when a person has secretly breached a contract, felt guilty but has neither admitted his guilt nor made restitution. The "symptoms" serve a double purpose: they communicate a sense of something being "wrong" with the person displaying them and provide an unintended, and inexplicit, "confession"; and they are a source of suffering and incapacity to the person displaying them and provide—again unintentionally—a form of atonement and motivation for change. The "therapy" of choice involves an explicit and detailed confession, followed by restitution, and reaffirmation, renegotiation or formal dissolution of the contractual understanding which existed between the defendant and the plaintiff.

This analysis has been focused upon a primordial social situation which can still be seen in play activities of children and among adults when minor issues are at stake. More serious matters are "taken to court." Judges and juries are designed to re-

solve disagreements, conflicts, and contract violations in such a way as to achieve justice ("judgment") and at the same time "keep the peace." Although in-group law and order sometimes break down (as in riots), most societies have sufficiently perfected "legal process" to prevent undisciplined retaliatory action. Mankind has not succeeded in extending the concepts and practices into the international sphere. We are not as far removed from the primordial interpersonal situation as it might appear.

The Contract, Chief Instrument of Social Solidarity, and Its Anomalies

We are inclined to think of "contracts" as formal legal devices. But contracts play a far more pervasive role in our lives. Every human interaction is on the basis of contracts, understanding, agreements, formal or informal, tacit or explicit. We go to school, work, get married, and have children with certain obligations, commitments, responsibilities—as well as privileges—in mind. And our more spontaneous, episodic activities involve "doing things with others," by consensus or prearrangement.

It follows that persons who refuse to make contracts or who secretly or openly violate them will experience life differently from the way in which responsible, authentic, cooperative persons do. There is a growing supposition that "psychopathology" represents deficient, excessive, mistaken, or violated interpersonal agreements.

Is there any form of psychopathology, "neurosis," or "sociosis" which does not involve some form of contract anomaly? In some ways, the most important form of contract disorder is secret, unilateral contract violation, i.e., cheating. No less important is the phenomenon of sociopathy, in which the problem is not so much contract violation, but undercommitment, characterlessness, lawlessness.

More subtle are the phenomena of over-commitment and mis-commitment. So-called ambitious people, the world's "go-getters," are over-committed, over-involved, in what is often an egocentric, socially unproductive way. But since ambition is commonly regarded as a virtue, it is difficult for the ambitious person to see the destructive role this mind-set plays in the lives of many men and women.

In some ways the most difficult to pinpoint is the phenomenon of mis-commitment. The problem is one of mistaken values, objectives, goals. It is usually possible to reach consensus about what is under-commitment and what is over-commitment. But when it comes to mis-commitment, it is more difficult. There is nothing within the theory of contracts that tells us what contracts we ought to make. This is where freedom, creativity, spontaneity, and hazard lie.

Whenever an attempt is made to relate morality to "mental health," an objection is voiced. The question of what affirmations, commitments, contracts one ought to make is open in a free society—and society must occasionally change its assumptions and procedures. Here is where imagination, individuality, and creativeness come into play. However, no society or individual can long endure unless commitments are faithfully kept—or, when difficulties arise, honorably renegotiated.

The plan for implementing "contract psychology" in "Institutes for Living" was at first hypothetical. Some progress had been made at Larned (Kansas) State Hospital. The

Jacksonville (Illinois) State Hospital is in process of inducing sweeping organizational, functional, and philosophical changes there. An institution for the self-rehabilitation of drug addicts meets most of the stipulations for "Institutes of Living." I refer to Synanon House and to Daytop Village, Inc. At the latter, one sees a motto: "Seek and Assume Responsibility," which is recognition of the fact that many drug addicts are sociopaths and under-committed. But attention is paid to the matter of contract keeping (as well as making), in meticulous detail, and to avoiding grandiose, egocentric overcommitment and mis-commitment.

One implication flows from contract psychology which explains the success of Synanon and Daytop and the relative failure of conventional institutions such as mental hospitals and prisons. The greatest weakness of these institutions is that it is not possible for their inmates, customers, "objects" to modify the institution's social system or to become integrated into it. These institutions provide "treatment" which will help the inmate to "go out" as a more adequately functioning member of the society, but this is to be done without participation in the society which is the institution.

An interesting question is whether we make contracts with ourselves, in terms of ideals, demands, aspirations, standards. Perhaps this is one aspect of conscience or the "ego ideal." It seems related to the Adlerian conception of "life style." Here is a fruitful area for further exploration.

If this analysis is sound, it follows that human beings have been misbehaving, sinning, getting out of community ever since the rudiments of corporate life. Since much of the difficulty arises from the secret, unilateral abrogation of contracts, some provision must be made for the restoration of deviants through confession and restitution. Recognition of this need has been undercut by a version of the theological model of man which offers the forgiveness of sins on easy terms and by the medical model which gives a prominent place to the concept of sickness and scarcely recognizes the reality of sin. It appears that secret guilt is a debilitating human reality which is handled adequately neither by "cheap grace" nor by medically oriented treatment.

It is postulated that the most satisfactory model for understanding modern man, particularly in the area of psychopathology and its better management, is contractual. When progressive education and permissive child rearing have been in vogue and "situation ethics" still is, this approach is certain to be dismissed as "legalistic" and "moralistic." But the fact remains that no society can endure which does not recognize and accept the reality and demands of legality and morality. The psychology and sociology of contracts provides the best way of conceptualizing the legal and moral dimensions of individual and corporate life, and all major forms of personality disorder (excluding those with a demonstrable organic or biochemical basis) can be identified as instances of contract anomaly.

Acting In and the Therapeutic Contract in Group Psychoanalysis

Louis R. Ormont

When a patient enters group analysis, he makes a contract with the therapist to talk, to reveal his thoughts, feelings, drives, impulses, wishes, fantasies, and dreams. The therapists agree to use this material to understand and make clear to him the meaningful story of his life. As the patient begins his task, he begins to falter. Soon he fails to do what he agreed to do. We study the way he fails and the reasons for his failure, and in the course of our study we find out how he sees the world and why he encounters difficulties.

There are many ways a patient may break his contract. Instead of relating the emotionally significant story of his life in words, he may communicate it in action, dramatizing the story through his behavior in the group. Such behavior has been called *acting in*.

The term has come to mean the reenactment by the patient of his life history, in a disguised fashion, within the therapeutic setting. Such reenactments are compulsive and repetitive. And because his acting in gratifies a hidden wish, he is apt to defend it fiercely or rationalize it even though it appears inappropriate to other group members.

We may distinguish between verbal and physical acting in. Verbal acting in requires no bodily movements. A patient may experience group therapy as an arena in which he can indulge himself with abandon, and instead of talking about his feelings, he expresses them. Physical acting in is more serious and often more difficult to deal with.

Difficult as it is to resolve acting in in individual therapy, it is doubly so in group analysis. For one thing, the group analyst has less control of the stimuli to which his patient is subjected than does the individual analyst. Group members who are predisposed to acting in may take the slightest hint from another member as a cue to act. Intense emotional interchanges can unsettle the foundations of a wobbly ego, foundations which a skilled individual therapist would have approached only later in the treatment. And when the actor in is acutely anxious, it may be difficult to get him to sit still long enough to examine what he is doing. His self-restraining mechanisms fail him, and his sense of reality is disturbed. This makes it difficult to show him connections between what he is experiencing and the events in his life at the moment.

One young man would make a beeline for the bathroom at the mention of sex. It took the combined efforts of the analyst and the group to convince him there was a connection between the subject matter and his urges.

Even when the patient who acts in has excellent insight into his behavior, the insight may have no effect on his actions. A perceptive architect could not desist from opening a window to let out a "foul thought" uttered by a group member or closing a window to keep out a tempting but unacceptable one uttered by another member. He knew the dynamics and the relevant historical facts and had discussed them with the group, but knowledge

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of the facts was not enough to help him control his compulsion. On cold days other members would shut the opened windows. This would start violent quarrels, creating uproar and confusion.

Persistent and unchecked acting in by a member may disrupt and demoralize a whole group, sometimes bringing its progress to a creaking, if not disastrous, halt.

Some therapists deal with the problem of acting in by the expedient of a careful intake screening. They look for impulse-ridden incidents in the prospect's background. Should these appear to be part of a life pattern, another approach may be the treatment of choice for the prospect.

But even a thorough screening interview may not enable a therapist to spot a very inhibited person with latent impulsiveness.

If the therapist has permitted transference relationships to develop within the group—and hopefully he has—every member will regress to an earlier phase of development, often to the preverbal level, a time when action was the only language. Faced with all these entrenched resistances, how can the therapist enlist the patients' reasonable egos on his side, get them to help him to uncover and work through their memories and feelings in words? First, he can lay the groundwork of group therapy in such a way as to minimize acting in. He can firmly establish the analytic contract at the outset, letting the members know what is and what is not expected of them. In brief, he expects them to come on time, pay their bills on time, preserve the group confidentiality, and restrict their activities to verbal communication.

He does this by bringing the first sign of acting in to the member's attention. The idea that members are expected to inhibit their actions in favor of talk is pointed up again and again, at the time of the action, but for the most part, it is well not to offer interpretations of acting in during this educational phase. Our opening statement of ground rules goes a long way toward reducing nonverbal communication. It also gives the members a language, an attitude, and the tools for use with fellow members who later make gestures toward acting in. Great therapeutic leverage is gained by pointing out the behavior at the beginning of the group experience.

Once the contractual agreement is spelled out, the analyst begins to make direct transference interpretations of deviant activity. Behavior is interpreted to the group members in the direction of who is doing what to whom. Members quickly grasp this object-oriented approach, and they become insightful with on-the-spot interpretations of acting in, detecting it in the subtlest interactions. Acting in is more often than not an expression of smoldering but unverbalized resentment. The analyst must be ever on the alert for telltale signs of this.

To make clear to the group members that dealing with acting in is the responsibility of the group as a whole, the analyst asks the members why they are ignoring this or that acting in or what they make of the acting in under discussion. As soon as the group assumes the responsibility of confronting the actor in, we are able to take a different tack. If the members ignore any incipent acting in, we place their oversight first on our agenda. Why aren't they doing their job? What attitude do they share about the member or his conduct that neutralizes their willingness to exam-

ine the deviant behavior? For this exploration, we usually select a member who has a stake in the aberrant activity. His stake may be a meaningful relationship with the person engaging in it, a fear of the behavior, or a recognition that he too engages in that behavior or is capable of it. Such a member can often shed much light on the prevailing mood or attitude.

From the group's point of view, the roots of a member's behavior are of secondary importance. An examination of the here-and-now precedes analysis of the content or origins of a member's activity. The question, "Why is he acting this way today?" should take precedence over any search for unconscious patterns or motives and dynamics. Such probing, if premature, may spark acting in. Hasty exploration of early damaging experiences may activate a complex train of psychic responses and catapult a member with shaky impulse control into destructive or self-destructive behavior.

Most decrees against acting in are undesirable. However, the therapist may at times be compelled to take stringent steps to preserve a group's effective functioning, and sometimes he may have to take urgent measures to protect the physical surroundings and property—let alone his patients.

When a patient who is temporarily incapable of using his reasoning powers makes an aggressive physical move toward another, the act must be interrupted. The therapist must spell out for him the potential effects of his acting in. It is inexcusable not to take a strong stand in the face of a threat of physical damage. Whenever a member mentions an act that involves physical violence, he must be asked why he thinks that such an act —rather than talk, feeling, and insight—will solve his problems? What feeling is he really talking about?

A sophisticated group can deal with acting in with little help from the analyst, but sometimes the burden falls on the analyst. Then nothing must be allowed to interfere with his single-minded attack on the problem, even if he must indicate that the situation is hopeless and that termination must be considered.

Even seemingly innocuous acting in calls for restraint when a member persistently engages in it. Unless such a patient learns to hold himself in check, he is unlikely to produce therapeutically significant material and this may make it difficult, if not impossible, to resolve his problems.

A readiness to use meaningful words instead of action for communication is a mark of mature ego growth in psychoanalytic therapy. Our primary task with acting in is to convert a tendency to act into a desire to talk.

Not until the positive transference is strong should the analyst adopt a prohibitive role. Proscriptions made prematurely can result in a therapeutic stalemate. Circumspection and caution are needed, for if clumsily handled, the decision to set limits may dress the group analyst in the robes of a moral judge, not only in the eyes of the actor in but also in those of the other members of the group.

If we read the evidence presented by our patients correctly, acting in has distinctive characteristics:

There is a tendency to re-enact a past event in disguise, often events traumatic in the early years of the member's life.

There is a tendency to reproduce a total historical experience rather than any select segment of it.

There is a need to play out the drama with almost anyone, unlike the

usual irrational transference attitude which attaches itself to significant people in the patient's life.

The acts of an actor in are entrenched, well-established, organized, and cohesive patterns. The action appears to be consciously willed. This is because the patient rationalizes every detail of it.

The patient sees no need, and consequently has no desire, to learn anything new or different.

Embedded in the action is a wish that the patient could not act upon originally. The original event is repeated but skewed in the direction of being more fulfilling and less noxious.

The actor in has an intense emotional stake in completing his act. Once it is finished, he derives great gratification from it.

He has a need to dramatize his activity and to seek out an unconsciously willing accomplice to participate.

The act has considerable social value for both the actor in and the participants.

The actor in tends to engage in magical thinking. He believes he need only make an act appear real in order to have it be real. Often he tends to experience his act as a magical way of warding off imagined danger.

Acting in presents the ultimate challenge to the group analyst. The handling of acting in takes considerable therapeutic judgment. The analyst must make the member aware that he has a choice regarding his acting in. The choice is between the gratifications provided by the aberrant activity and the insight which could be provided by stemming it. Without instilling such awareness the analyst cannot hope to foster the growth of an autonomous ego and the sense of dignity that goes with it.

The Tattooed Psychiatric Patient

N. L. Gittleson, G. D. P. Wallen, and K. Dawson-Butterworth

All tattooed patients entering an acute admission unit over a 12-month period were studied and compared with those who were not tattooed. These groups are designated Acute Tattooed and Acute Control groups.

In addition, the chronic male population of the hospital was screened for tattooed patients (34), who were then compared with the non-tattooed chronic population of one "firm" (179). These groups are designated Chronic Tattooed and Chronic Control groups respectively.

Of 218 acute patients 15 percent were tattooed. In the acute groups, personality disorder is significantly more common in the tattooed than in the non-tattooed, comprising 48 percent of the former.

In the older chronic groups, personality disorder is infrequent as such cases seldom become chronic inpatients. Schizophrenia, however, is significantly less common in the tattooed than in the non-tattooed—a tendency seen in less marked form in the acute groups.

Despite the 21-year mean age difference between the Acute and Chronic Tattooed groups, there is no significant difference between their mean ages when first tattooed. In the tattooed group as a whole, personality disorder is significantly more, and schizophrenia is significantly less, common than in the non-tattooed group.

The tattooed group comprises 17 patients with personality disorders (alcoholic 7, inadequate-asthenic 3, explosive-aggressive 2, sensitive 2, attention-seeking 2, sexual deviation 1), 31 schizophrenics, and 19 other diagnoses.

A history of tattooing in the family is more frequent in the personality disorders. Those with personality disorders had been tattooed on more than one occasion more often than the schizophrenics and those with other diagnoses. Although they had been tattooed on more occasions the mean age of those with personality disorders was significantly younger than that of the schizophrenics and those with other diagnoses. However, the mean age when first tattooed did not differ between the three diagnostic groups, the overall mean being 19 years.

All patients were asked about their reasons and motives for being tattooed. Forty-five patients were conforming to and/or following a contemporary group craze or fashion; one was consciously imitating his father; for eight patients being tattooed was an "ordeal" by which they proved their masculinity and toughness; two disobeyed their fathers' orders not to get tattooed, as a means of asserting their independence. Only four patients gave "decoration" as their motive. In two cases talismanic protection against ill luck or ill health was the motivation. One schizophrenic said that the voice of Florence Nightingale in his head had ordered him to get tattooed, and another had been tattooed as a result of "orders" received during a passivity experience. Three patients were unable to remember their motives.

The circumstances surrounding the first tattooing showed no differences in the three diagnostic groups. Fifty-five percent were in the Armed Forces, and 10 percent were in prison at the

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time of the first tattooing. Complete sobriety when first tattooed was claimed by 49 patients. Only 25 percent were unaccompanied when first tattooed, and only 15 percent did not mention groups of friends as the main instigation. Seventy-five percent were first tattooed in their own country.

The tattoos of the personality disorder group were more often visible when normal clothing was worn than those of the schizophrenics and the other diagnoses.

The diagnostic groups did not differ in their attitudes to the tattoos. Twenty-eight percent did not want their tattoos seen by others, 40 percent did want other people to see their tattoos, and 31 percent were indifferent. Asked whether they wanted their tattoos removed if surgery was available and gratis, 21 percent wanted removal, 75 percent wanted to keep their tattoos, and 4 percent were indifferent.

All but one case was tattooed on the forearm, which was the most common site. No group was associated with any pattern of site or content of the tattoos.

The tattooed group was analyzed by comparing those who had been tattooed on one occasion with those who had been tattooed on more than one occasion. The patient who has been tattooed on more than one occasion is more likely to be categorized as suffering from a personality disorder and as being a lawbreaker than a patient who has been tattooed on one occasion only. He obtains his first tattoo at an earlier age, and his tattoos are more likely to be visible in normal clothing. It is of interest that 21 percent were tattooed on both sides of the body at their sole tattoo session.

Only two tattooed females were found among the 938 female patients admitted during the 12 months study-period and none in the "chronic" wards. These two conformed to the pattern exhibited by the tattooed males. Both had severely disturbed personalities, a history of disturbed childhood, and criminal records. Both were in a group and young when first tattooed. Both were tattooed on the forearm and upper arms and regretted it. One had been tattooed on three occasions, the other on one.

The Fermeda Workshop: A Different Approach to Border Conflicts in Eastern Africa

LEONARD W. DOOB, WILLIAM J. FOLTZ, and ROBERT B. STEVENS

The Fermeda Workshop was an attempt to determine whether sensitivity training could be employed in an international setting. The disputes with which the Workshop concerned itself are between Somalia and Kenya and between Somalia and Ethiopia. One fact in these situations is uncontested: the majority of the inhabitants of the Ogaden which is part of Ethiopia and of the North Eastern Province which is part of Kenya are ethnically and linguistically Somalis who use the land as grazing grounds for camels and cattle. The conflict between the nomadic tradition and the boundaries based on the colonial tradition have kept that part of Eastern Africa at war or near conflict for almost a generation.

We sought English-speaking African scholars from the three countries who would be qualified and interested in participating, to obtain informal permission of the three African governments and to raise financial support. We located a ski hotel, the Fermeda, in the South Tyrol of Italy. There, in the midst of woods and mountain streams and against a backdrop of the Dolomites, we met from August 2 to August 14, 1969.

The group consisted of 26 persons: 18 Africans, four trainers, a secretary, and the three of us. Most of us assembled in Rome and established a common bond by journeying on a bus to Fermeda. At the hotel, each African, with two exceptions, had his own room. Seating at meals was optional so that individuals from at least two African nations sat together; the Americans were scattered at different tables.

The participants had been told that the first part of the exercise would concentrate on training in communication skills. After the first session which was attended by everybody—a session of the entire group became known as the General Assembly—most of the interaction and exercises were carried on in two T-groups. These groups were selected in such a way that they contained three participants from each of the three countries whose professional interests were more or less balanced; two of us, (lawyer and psychologist) were in one group, and the third, (political scientist) was in the other.

Some exercises could have occurred in any sensitivity training workshop. Participants complained about the unstructured character of the meetings; they yearned for a chairman, parliamentary procedure, and agenda. Some aggression against the trainers, us, and one another was fierce. Conflict occurred between individuals belonging to the same or different nations. The participants wanted the training to begin when, in fact, they were in the midst of it.

Sessions usually ended by self-evaluation of what the group had accomplished, although resistance to this was never broken. Games in small groups were played in traditional T-group fashion. The initial lecture established the distinction between content (what you say) and process (what you mean, what your motivations are); a later one outlined factors which make for group cohesion.

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Preliminary training differed from ordinary sensitivity training in many respects: The participants did not come from a "single organization." Across nations they were strangers. Within a country they belonged to the same university, or in the case of the Somalis from the same educated community, but few were in the same clique. The aim of the training was not individual therapy, nor improvement of relations within a group, but a more nebulous goal: possible solutions for border disputes.

Overshadowing training was knowledge that despite the idyllic surrounding, we had assembled to discuss these disputes. Some participants complained they would reveal nothing personal because, they claimed, we were delaying the progress of the Workshop. Others sought to learn as much as they could about sensitivity training because they believed such knowledge would help them professionally. The trainers understood this dilemma and handled it excellently. One of the most successful games involved competition between small groups in waging war or disarming (The Disarmament Game). Topics such as the nature of conflict, the Organization of African Unity, and university-student disturbances were discussed in the early T-groups because their processes seemed to relate to the border disputes.

From our standpoint we were in a strange predicament. As participants, we experienced some of the *Sturm und Drang* of any workshop. Then the real participants, the Africans, kept reminding us that we were not ordinary participants, for we had organized the enterprise, held the purse strings, and one of us was looked up to as a father figure. In addition, we were observers interested in eliciting information about attitudes and values in a manner ordinarily not accessible to conventional research techniques; and our African friends, looking upon us as three Americans, kept observing our reactions to personal stress and their political problems. We tried to avoid injecting our conceptualizations of political problems into the discussion, although we achieved that goal with differing degrees of success.

Toward the end of the first week, the trainers and we decided to shift from sensitivity training to the issues of the border disputes. We had planned a break of two days—most of the Africans and Americans went to Venice which offered a sharp contrast to Fermeda—and so before then we encouraged the participants to "ventilate" and to a lesser degree to "diagnose" the border disputes. This they did by working in national groups with the instruction to list their grievances against the other country or countries and to anticipate their opponents' grievances.

After Venice, we concentrated upon the border disputes. Possible solutions were listed after small group "brainstorming sessions." Overall plans were drawn up in the T-groups, with the intention of being presented ultimately to the General Assembly.

As social scientists will, we approached the Workshop with partially defined expectations. One expectation was that nationality would provide the most salient principle of association, trust, and like-mindedness among the Africans. These expectations proved more nearly false than true. After the first day, observable informal groups of both a substantive and recreational nature almost always included more than one nationality.

Our strongest surprise came toward the end of the first week when participants were asked to caucus in national groups to accomplish a substantive task. Reluctance was widespread, and two of the three groups insisted on redefining the task in a less sensitive direction once they had agreed to meet. In individual conversations with us, participants suggested that a lack of trust in their fellow countrymen was a motivating factor in at least two of the national groups. When dealing with sensitive issues, many participants preferred to associate with persons with whom they could expect to have only exceptional contact once the Workshop ended.

Nationality became more salient at the end of the Workshop. Two factors appeared to be at work. As the discussion focused on the substantive issue and as easy solutions proved inadequate, national positions became more solid and salient in determining patterns of interaction. Something of a "reentry" phenomenon occurred during the last two days when several individuals retreated from established conciliatory positions in a manner to suggest that they were preparing a safe record of suitably nationalistic statements.

Other expectations related to mechanisms through which the African participants might build interpersonal solidarity among themselves or avoid confrontation with the substantive issues dividing them. One mechanism likely to be useful would be building of solidarity on the basis of antiwhite sentiments. At no point was such sentiment mobilized. Specific condemnations of acts or policies of specific groups of whites were frequent, but were usually not misplaced nor did they betray any latent purpose.

A second expected mechanism was the avoidance of conflictual substance in favor of utopian appeals to political unity of all Africa. This was much in evidence. The mechanism served two purposes: to avoid concrete problems whose discussion might lead to disharmony within the group, and to soften conflictual assertions by reassuring one's opponent that opposition was temporary and that nothing personal was implied.

One further (and unexpected) mechanism was a willingness to criticize one's own government. We cannot assess the sincerity or depth of these feelings—much less their legitimacy—nor can we draw conclusions about connections between overt statements, internalized attitudes, and any concrete action.

Each T-group developed strong loyalties. Visitors from the other group were treated as interlopers. In classic style, the T-groups began in confusion, proceeded to frustration, and suddenly coalesced to conduct an impressive and profitable discussion without benefit of formal leadership or agenda. Both groups returned to the initial frustration during the first sessions in which the border dispute was discussed. After that, one T-group made greater progress than the other. The difference is perhaps explained by the presence in the laggard group of an individual whose aggressive, uncontrolled behavior, often exacerbated by drink, seemed to be idiosyncratically determined.

In contrast to the T-groups' success was the weakness of the General Assembly. Avoidance behavior, intransigence, and posturing and undercutting reappeared in the General Assembly. One procedural sign of difficulty was the Assembly's reliance on formal parliamentary procedure.

Rather than a cause of the General Assembly's difficulties, the exacerbated parliamentarism seems more a reaction to them. The trainers felt, in retrospect, that a different design with more emphasis on sensitivity training in the plenary session could have overcome the difficulty.

The workshop confirmed the dictum that expression of attitude depends in part upon the situation. We witnessed instances of the same person expressing, for example, conciliatory views in his T-group and then being silent or defending a rigid position in the General Assembly. Perhaps the T-groups succeeded too well and prevented the participants from transferring their attachments to the General Assembly or the national groups.

We hold the tentative opinion that no fundamental changes were wrought by the Workshop, but that new political, economic, and social facts may have been learned. The participants had the opportunity to discover that their antagonists were men of good will who subscribed to opposing viewpoints with an intensity and conviction as strong as their own. This insight may possibly have repercussions and produce change—eventually.

The Fermeda Workshop did not end with a communique proposing a single peace formula, but it did produce general agreement on a two-stage approach involving neutralization of disputed areas during the initial period. This approach was embodied in two proposals, with each commanding the assent of some influential citizens of all three countries involved in the dispute. The important steps have to be taken by the politicians of the three countries. We can now investigate whether these incremental gains of the Workshop are communicated to the men whose actions could make a difference.

From a research point of view, the technique revealed attitudes and complex cognitive processes not obtainable through more standard techniques; but the Workshop involved a small sample of persons, and data have been derived in a form that makes coding difficult. The lack of a control group was unavoidable. The fact that the sample's composition is known to the governments concerned poses confidentiality problems. Against such difficulties, one advantage stands out. In contrast to the usual relation between researcher and subject no information was available to us which was not equally available to the African participants and, should they so choose, to their governments as well. It will be through the African participants' public and private communications that the Fermeda Workshop will have its greatest impact.

The main objective of the Workshop was not achieved. No original solution was evolved. But the travail, the time, and the expense are of little importance, if a Fermeda-type workshop contributes even marginally to the settlement of a major international dispute.

The Psychology of Treason

JAMES ALEXANDER

Dissent is peculiarly prevalent at the present time, and seems to deserve psychoanalytic study. Some forms have socially constructive effects, but many do not. Treason and sedition are usually regarded as destructive forms of dissent. This value judgment is partly determined by who profits from, or suffers from, the act of treason. The advantage the traitor reaps in power, material gain, revenge, etc., is offset by the object of his new allegiance feeling that he is not to be trusted too far.

There are few psychological studies of treason or sedition. In psychoanalysis, there are many studies of persecution, e.g., anti-semitism, but few of treason. Treason is an act belonging to the wider domain signified by terms such as treachery, betrayal, traitorousness, perfidy. All the terms have meanings denoting breach of loyalty by someone, or by some group to another group, where the latter has legal and moral claims to loyalty by the former. Treason has always been severely punished. Hitherto, the person contemplating treason accepted the risk, hoping to succeed; but knowing that if he failed, the punishment would probably be death. Recently, when treason has been detected in the form of espionage, the accused asserts the right to treason.

Nations often are spoken of as mother country or fatherland by the citizens thereof. These are modern representations of national pride and pride in one's national identity.

A Finnish friend of mine said, after spending a year in the United States, that he was impressed by the number of Americans who had a secret yearning to be at one with the enemy. This secret sympathy with the enemy is an important root of treason. Extreme ambivalent love-hate of the parents exists in the traitor, and it is organized in ways similar to the ways in which his parents relate to their objects.

The enemy nation or political movement becomes the recipient of the repressed love unwillingly felt toward the hated parents. The realignment of loyalties is an attempt to become free through breaking the unconscious hostile-dependent, guilty, love, which fetters the traitor in a slavish servitude to the parents. The hate of the parents is displaced on one's own nation and is rationalized so that consciously one's own nation is convicted of crimes, follies, and morally indefensible attitudes and aims.

In all this, there is a large element of revenge upon the parents. The parents of the traitor love their child in a disloyal, hostile, erotic way, all unacknowledged by the parents to themselves, or to their offspring. These children have never felt forgiven for anything which the parents have held against them. The child identifies with them, and so becomes like them and has all his object-relatedness organized in a manner quite reminiscent of the ways in which his parents relate.

Treason has not only social, political, and legal implications, but moral-ethical implications. Treason, or strong treasonable and seditious potentialities, implicate large areas of the personality and character struc-

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ture of the individual in a pathological process. The primary structural sites of these pathological processes are defects in the superego and ego-ideal. The ideal of loyalty as a strongly cathected value in the ego-ideal does not exist in the traitor. It is weak compared to the strength of feelings of hate and desire for revenge. It does not forbid disloyalty and treason.

We all have negative and positive feelings toward everything. This ambivalence is a different thing from the extreme form one encounters in treason. The person with the character defect that makes him liable to treason has extreme ambivalence of the black-and-white character. Those with little tendency to disloyalty may have black-and-white tendencies, but unambivalently. They love their friends and hate their enemies. The traitor represses his love for his parents, denies it and displaces it upon those whom he should relate to as enemies. The unscrupulous power-hungry are always looking for a traitor in the camp of those opposed to the ambitions of the power-hungry to actualize the potential treason of the disaffected.

I would now like to compare the character structure of the treasonable personality with that of the "fool." The fool does not admit his malice, so his defection is not traitorous with malice aforethought. The person who commits the act of treason admits his hate to himself, but justifies it by rationalizing it; his acts of treason are conscious, deliberate, planful.

The person who commits, or is liable to commit, treason is related to the neurotic character type of the "fool." The fool is more prone to feel guilt, so represses his vengeful wishes. His destructive acts must come as sudden breakthroughs at moments of stress, when he acquires a not previously possessed "justification" for what he unconsciously wished to do. The difference in the typical fool and the typical traitor is a difference in the structure of their superegos and ego-ideals. The superego of the fool is less tolerant of open admission of hate. The traitor can consciously admit to himself hatred of his own group, though he too has guilt feelings which he deals with by the rationalization that his own group has forfeited his loyalty through their baseness, perfidy, inhumaneness, etc.

The ego-ideal of the fool demands that he profess the ideal of loyalty. The traitor's ego-ideal does not demand that he profess to himself the ego-ideal of loyalty. The traitor, feeling less guilt, has more courage. The fool is reckless, not courageous. Readiness to feel bitterness is characteristic of the traitor. He broods humorlessly over injustices, real or imagined. The traitor begins to plot vengeance against his own group by which he feels insufficiently recognized and rewarded, or which he feels have betrayed their own ideals, whereas the fool cannot admit bitterness, anger, or vengeful wishes. At most, he admits skepticism, of being unconvinced in his broad-minded fairness of the integrity and wisdom of some policy his group is pursuing.

This is a real possibility. The majority is not always right. In the case of the fool, this truth is debased since it is used by him only as a rationalization. The traitor does have a seemingly strong independence which allows him secretly to dissent. This sly aggression is probably more dependency protest than genuine independence. The fool pretends to be above narrow factionalism, but this

is really only a lack of communication. The fool is likely to be more concerned about public opinion.

Betrayals in the formative years of the fool were covert, not open, as were the betrayals in the developmental history of the traitor. The nurturing milieu of the fool kept up the pretense of subscribing to decent motives. In the developmental history of the traitor, the significant figures made no pretense of being identified with the mainstream of society, but displayed a rather paranoid attitude toward the establishment.

Despite treason being a negative ego-ideal in Western civilization, it has occurred often, many times producing havoc. So-called brain washing is easier for the enemy if there exists a latent tendency to treason. The more potential treachery in the individuals comprising a group, the more easily group morale is damaged by even small reasons for disaffection.

What is there, if anything, good to say about treason? I will quote Rebecca West (*The New Meaning of Treason,* 1967), but with grave reservations:

> There is a case for the traitor. He is a sport from a necessary type. The relationship between a man and his fatherland is always disturbed if either the man or fatherland be highly developed. . . . Men must be capable of imagining and executing and insisting on social change, if they are to reform or even maintain civilization, and capable too of furnishing the rebellion which is sometimes necessary if society is not to perish of immobility.

If we accept treason and sedition as sometimes justified and constructive, how are we to distinguish such instances from the criminal, psychopathic, destructive varieties? Certainly not by giving fullest sway to unlimited partisanship, but by maximum objectivity, and judging by the most elevated ideals of fairness. Ultimately, the moral quality of treason and sedition will have to be judged on the basis of motivations of the persons engaged in treasonable and seditious activities.

Obviously, such individuals do not come into psychoanalysis or any kind of psychotherapy because the person guilty of treason does not regard himself as ill. His countrymen regard him as a criminal. The nation to which he has defected regards him as a foolish tool to be exploited.

Seditious tendencies are a somewhat different case. Persons with seditious tendencies will be found incidentally in persons coming into treatment for other reasons. Recognition of the treacherous, seditious, or treasonous tendencies will permit the analyst to attempt to analyze this characterological defect, and working through can lessen the destructive potentialities. The seditious and treacherous tendencies can serve like a fault (in the geological sense) leading to deeper conflicts, such as destructive identifications.

What Is Adaptive Training?

CHARLES R. KELLEY

The primary requirements of adaptive training are that performance be continuously measured, and that the measurement be employed to make changes in the stimulus, problem, or task. The instructor varies the difficulty of the tasks that he gives to a student as a function of how well that student has been performing; individual instruction is by its nature adaptive. When instruction is given to groups, it is more difficult to vary the task with a student's level of performance. Similarly, when automatic training devices are used, the sequence of tasks is preprogrammed, and runs its course irrespective of performance.

Machine-controlled adaptive training is the automation of a function performed by the skilled individual instructor. The essential feature of adaptive training is a feedback loop by means of which the problem, stimulus, or task is changed as a consequence of how well the student is performing. An adaptive training system is a closed-loop feedback system. Just as open-loop control is less flexible than closed-loop because control must be preprogrammed, so fixed training is less flexible than adaptive. As training has become mechanized, the function of this adaptive loop and the importance it plays in the training process have begun to be clarified.

Machine controlled adaptive training has three elements: a means for measuring performance, an adjustable feature of the task or problem which changes its difficulty, and adaptive logic which changes the adaptive variable as a function of performance.

In common-sense terms, machine-controlled adaptive training automatically gets harder as the subject becomes more skilled. As a consequence, the same equipment can be effective for a range of skills, from those of the neophyte to those of the expert. Whatever the level of skill, the system adjusts itself so that tasks are suitable to skill level.

Adaptive training is efficient, because it is only when training is at an appropriate level of difficulty that effective learning can take place. For this reason a fixed program of group instruction is apt to be effective only for the "average" members.

The first machine-controlled adaptive device in the continuous control field was developed in 1959. This was a special-purpose device to measure an operator's ability to track high frequencies. A subject operated an oscillatory tracking system. His tracking error was smoothed and time-averaged through a filter, and then employed to adjust the speed of oscillation; the smaller the error became, the higher became the frequency of the system's oscillation. When a subject tracked poorly, the system would oscillate slowly; when a subject tracked well, the frequency of oscillation automatically went up.

One way of simplifying an automatic tracking system is to add derivatives of error into the display signal. This is called "display augmentation" or "quickening." The adaptive circuit in each trainer automatically governed how much display augmentation the trainee received. The performance measurement circuit took the absolute error or the error

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squared, averaged it over time via an exponential filter, and used the smoothed error signal to control the amount of display augmentation via a multiplier. By subtracting a constant, from the smoothed error signal, the display augmentation (quickening) signal was made to disappear altogether when the error became as small as the constant. With this system, as the trainee tracked poorly he received a great deal of help from the display augmenter, but as he improved his tracking, this help gradually disappeared. When he finally reached the preset criterion of performance, there would be no display augmentation at all.

Implementing an Adaptive Training System

There are three elements in the adaptive trainer: the adaptive variable, the performance measurement, and the adaptive logic. The adaptive variable may be any adjustable feature of the trainer which systematically affects task difficulty. The adaptive logic performs the interconnection between the performance measurement and the variable aspect(s) of the task that form(s) the adaptive variable.

Examples of aspects of a task that can be changed to serve as adaptive variables are:

The simulated environment may be changed (e.g., illumination, sound level, temperature, or simulated gustiness or turbulence).

Stress applied to the operator can be varied (e.g., g-forces, vibration, oxygen pressure, drugs).

The controlled element (simulated vehicle) can be modified (e.g., by varying the gain of a stability augmenting signal).

The operator's control can be varied (e.g., by adjusting its gain, simulated feel, or backlash).

Displays can be varied (e.g., by changing the gain, lag, amount of "quickening" of a quickened display, or prediction span of a predictor display).

Problem generation may result in harder or easier command trajectories maneuvers, etc.

Secondary task loading may be changed adaptively, adjusting, for example, the communication load, or the fluctuations in engine instruments requiring monitoring and adjustment.

Any one or any combination of adaptive adjustment variables can be employed. The essential requirement is that an adaptive variable systematically affect the difficulty of the task, and all of the above fulfill this requirement.

The measurement of performance employed to adjust the adaptive variable must be selected with care. If this measurement is unreliable the adaptive variable will fluctuate in an erratic manner.

Performance may be measured in several dimensions, or several different performance measurements may be combined into a single index. The measurement may show how well a trainee is doing at a given moment, or it may be averaged over time. Whatever measurement is employed, it is important that it be tested, so that its usefulness in a particular adaptive system is demonstrated.

The way in which an adaptive variable (or combination of variables) is tied to measured performance is the adaptive logic of the system. This logic is sometimes expressed in the form of an equation describing the precise mathematical relationship be-

tween a performance measurement and a given adaptive variable. The adaptive logic may, however, be expressed instead in terms of adjustment rules. An adjustment rule might say, e.g., that the system will be made more difficult at a certain rate when each of several criteria of performance are within defined tolerances.

Mistakes are commonly made in mechanizing the logic of an adaptive system. One common mistake is to have a system that adapts too quickly, as a result of which "random" elements in performance cause the system to fluctuate excessively in difficulty. Learning is a gradual process. Once an appropriate initial level of difficulty has been established, it is only necessary that the adaptive training device change its difficulty level at a rate commensurate with the progress of learning.

In training, it is important to keep the trainee informed of his progress or lack of it. Adaptive systems deprive the subject of his usual source of knowledge of results, which is changes that take place in the performance measurement. Under these circumstances it is important that a supplementary knowledge-of-results display be provided. A meter which indicates the exact level of difficulty of the system at each moment supplies the required information in an effective form. A signal corresponding to level of difficulty is readily available in the adaptive simulator, since level of difficulty corresponds to the adjustment level of the adaptive variable. One or more indicator lights showing out-of-tolerance conditions are helpful knowledge-of-results displays, especially in early stages of a difficult multivariable task.

Adaptive techniques are one means by which training can be made more effective. They are by no means a panacea. An "invalid" training system will not acquire validity by being made adaptive. In addition, adaptive training is new, and there are a hundred ways that it can be done badly. Training devices can be made less instead of more effective by being made adaptive in the wrong way.

Each adaptive training device must be developed individually, and be judged on its own merits. A well-conceived and well-mechanized adaptive training system should be more effective than an otherwise similar system in which the difficulty level is fixed throughout training. Major questions about adaptive techniques and their implementation remain unanswered and will only be clarified with progress in this new area of training research. In the meantime, the practical question will continue to arise as to how a particular training device or system can best be made adaptive.

The Psychosocial Aspects of Advanced Cancer

EDMUND C. PAYNE, JR. and MELVIN J. KRANT

The care of a patient with a long-term illness that is debilitating and progressing toward death, such as advancing cancer, is difficult for the physician, other members of the health professions, and the family.

This issue is not simply one of the physician's kindness nor of his sympathetic concern, important as these qualities are in medical care. Failure to comprehend the psychological concerns of the patient and family may produce unnecessary and even ill-programmed therapies that cannot succeed in alleviating the patient's complaints, much less the associated anxieties.

The physician's response to a patient's anxiety cannot routinely be a psychiatric consultation. Every patient undergoing a change from health to disease experiences anxiety and concern. There will never be enough psychiatrists to deal with this universal human suffering and distress. Comprehensive care of the patient with a serious medical illness must remain the responsibility of the internist or surgeon, and this care must include recognition of the social and psychological dimensions.

A review of medical records reveals a dearth of information relative to psychologic factors. A survey of 15 randomly selected charts showed that in only two instances did the physician record what the patient had been told about the illness. In only seven instances was any reference made to the patient's emotional state. Only in three cases was there any indication of an attempt to appreciate and alleviate the patient's unhappiness.

Doctors put into their charts what they consider to be important. So do authors. A review of several textbooks failed to reveal any discussion concerned with the psychological or social implications of disease.

A program for fourth-year medical students was inaugurated three years ago in the Oncology Division of the Lemuel Shattuck Hospital to study problems in and methods for improving communication and management. A consulting psychiatrist and the senior physicians of the Oncology Division met weekly with four to six students to discuss attitudes in patient care.

The students were assigned to the medical units for a two- to three-month period. Patients with chronic diseases are referred to these wards from private physicians and other hospitals in the vicinity. Many patients with advancing cancer were included. The student was involved in patient examination and care, and worked alongside medical residents, the senior ward physician and had consultation visits in various specialties, including oncology.

The conferences were conducted in an area apart from the ward units; participants included the students, social service workers, student nurses, ward nurses, the consultant psychiatrist, and the oncology physician. The students selected a case for presentation. The case was usually selected because of a problem in discussing an issue with an individual or because of some difficulty in management. During the first few sessions, the psychiatrist interviewed the patient, but

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gradually the student proceeded with the interview himself. A lengthy discussion period followed these interviews. These sessions usually revealed that problems existed in the student's and the physician's on-the-ward history taking, which reflected defects in conceptualization of the patient's situation. The students failed to obtain information concerning the patient's reactions to disease, relation to important people in their lives, and concepts of the physician and the hospital. In looking at the medical record and in discussing the issue with the students, a similar lack of information on the part of more senior physicians was evident. The lack of the senior staff's attention to this area results in a deficiency of appropriate instruction.

These conferences demonstrated that every patient with a serious illness has some knowledge of the pathological processes occurring in his body. The type of knowledge and the way in which it is organized depend on the symptoms produced by the disease and their effect on the patient's functioning, on the specific informational feedback (either explicit or nonverbal) which he receives from his physician, friends, and family, and on his own methods of dealing with threatening information. Most patients had been referred by an outside physician, and many had seen several physicians. Some information about their illness, realistic or distorted, bluntly stated or euphemistic, had been transmitted to all of these patients by their previous physician.

Most of the cancer patients whose disease had been regarded as potentially curable had been given some indication that they had a malignancy. Those with inoperable conditions reported receiving more varied information. In a minority, the physician had given the diagnosis more or less directly, although the fatal import of the condition was controverted, softened, or not dealt with. Other physicians had conveyed a diffused and euphemistic picture. Some patients reported that their physicians had avoided any discussion of diagnosis, a strategy which the patients avoided challenging but to which they reacted with anxiety.

The reactions of these patients showed a range that was determined by their characteristic style of dealing with danger and by the stage they believed assumed by their doctors. At one end of the spectrum was the unusual patient who assimilated a relatively undistorted understanding of his illness and its implications. This response was never solely the product of frankness by the physician. Always the patient had taken the step of integrating the information and drawing his own conclusions. More common was the acceptance of the diagnosis, but a wishful reliance on the hospital for treatment or on the current physician to reverse the verdict. Other patients clung to euphemistic designations of their disease, floated in vague concepts of the illness unmarked by any delineation of its nature. Some few patients evaded questions which directed their attention to this problem.

The initial observations indicated that the approach of students and most ward physicians was to avoid discussion with the patients about the nature of the disease. The referral note transmitted information as to the patient's diagnosis and prior therapy, but almost never was mention of the psychological impact of diagnosis

or therapy, and seldom would the transfer note indicate what information had been transmitted to the patient or family. With few exceptions, the patients, once admitted to the Lemuel Shattuck Hospital, were not asked what they had been told about their illness, and in no instance was this information recorded on the patient's record. A discussion with the patient of his emotional reactions to the illness was equally avoided.

The interviews revealed that most patients were deeply concerned about dying. Most were depressed and frightened, but warded off these affects by clinging to hope that they would be restored to health in the hospital. These attitudes were on the surface of the patient's awareness and easily elicited. Most patients responded eagerly to an expression of interest in their feelings and to an opportunity to express them. At times the patients revealed information that cast light upon a physical problem. A woman with spinal metastases from a breast carcinoma, who had been told that her spine was affected by the cancer could not be persuaded to move from a supine position. Neurological examination revealed no abnormalities sufficient to account for this paralysis. She revealed a belief of delusional intensity that her spine had been eaten away and that any movement would cause her to break in two. As this belief was revealed to be unfounded, she was persuaded to sit up and gradually become ambulant.

Communication between physician and patient as to the psychologic impact of disease and about the patient's conception of the illness is important if the physician aspires to more than a mechanistic standard of medical management.

A 53-year old woman with metastatic carcinoma admitted for consideration of treatment was to be discharged following a decision that no treatment should be offered. The physician commented on her bland, cheerful attitude during her hospital stay. He said that he had not discussed discharge with her but assumed that someone had. In the conference, the patient responded to the interest in her personal views and feelings by telling how frightened she was. She suspected that her illness was a very bad one, but had never discussed this either with her physician or with doctors in the hospital. She had felt despair before coming to the hospital but became optimistic when plans for hospitalization were made. She was patiently waiting for treatment to begin and did not suspect that her discharge was imminent. The misconceptions under which this woman labored demonstrate the extent to which communication had failed. An abrupt discharge without further clarification and before she made new adjustment with her doctor's assistance, could have been catastrophic. Lengthy preparation for discharge was obviously necessary.

For most people, dying is an isolated and lonely experience. Friends and family are uncomfortable, avoid him, and when with him, assume an air of artificial cheerfulness that blocks communication in the area of most concern to the patient, his distress and illness. Similar avoidance by the physician intensifies this isolation; sensitive inquiry into these concerns helps alleviate it. The purpose of these conferences was to demonstrate that open discussion with patients is possible, and that information

acquired can be used for medical planning.

The physician frequently fails to obtain necessary information about the patient's relationship with the people closest to him. A patient with a prolonged illness suffers an impairment of self-sufficiency and is dependent on his environment for physical and emotional support. The physician must assess the extent to which the spouse or other family member can provide this support.

A person responds to the serious illness or threatened death of a spouse, parent, or child with a mixture of painful emotions consisting of grief, anxiety, fear of loss of accustomed support, depression, and even anger. At the same time that demands are being made to give nursing care and emotional sustenance to the patient, the family member may be immersed in this personal upheaval. This situation is often compounded by the breakdown of communication that occurs even with couples who had an intimate and open relationship prior to illness.

The physician must evaluate the strengths and weaknesses of the family before sending his patient home. In some instances such a plan would overtax the family's emotional resources, and some alternative, such as a nursing home or a hospital for prolonged care, must be considered. Auxiliary services such as the Visiting Nurse Association, homemaker services, or a skillful social worker can provide support. The physician cannot make these decisions wisely without a careful initial and continuing discussion of the reactions with the family members. Joint discussions with patient and spouse can sometimes offer a model of frankness that makes subsequent communication between them easier and freer.

The reluctance of students and physicians to investigate their patients' knowledge of and reaction to illness, and their consistent (wishful) tendency to underestimate the patients' distress seem related to a variety of factors. Two stand out. The most easily discernible motive is to protect themselves from sharing their patient's painful feelings. The physician exposes himself to a milder and time-limited degree when opening and exposing the patient's feelings of anxiety, fear, depression, and helplessness. This is not only painful but may also activate the physician's unresolved conflicts concerning death, mutilation, and loss. A student physician who was adamantly opposed to inquiry into patients' feelings and who advocated a mechanistic approach to medical management blurted out that he had experienced personal losses and such an exploration was for him too painful to consider.

The second reason is simply lack of knowledge of how to conduct such a discussion. Few students, or house officers or senior physicians, had seen a tactful inquiry into these areas, and feared such an investigation would evoke emotions in their patients which would get out of control and damage their patients.

Demonstration interviews, conducted initially by the instructor and increasingly taken over by the students, were effective in helping students overcome their apprehension and successfully include these areas in their history-taking. The important facts were: discussing the relevance of this material; demonstrating how it could be applied to patient management; and the most essential step, demonstrating the simple interviewing methods by which this information

could be obtained. Although the long-range effects of their care of patients cannot be determined, they did discuss these matters with patients, often for the first time, and discovered that the questions can be asked without excess trauma for doctor or patient, and that useful information can be obtained. Further, the information could be documented on the patient's chart. Once recorded, changes in affect, attitude to disease and treatment, and other psychologic or social factors could be noted as part of the follow-up notes, and the information would become available to the next reader of the chart.

Several recommendations seem relevant. Training programs in simple psychological interviewing should be made available for physicians. Psychiatrists may well take initiative in developing such a program in university and community hospitals, but active participation by respected instructors in medicine and surgery is essential. Information obtained in patient interviews should be considered as important as the routine history and physical examination, and should be entered onto the medical record. It is insufficient to check off "depressed" or "not depressed." We suggest that the following information be recorded.

What has the patient been told about his illness?

What conclusions has the patient reached about his illness?

How is he coping with his illness? Can a degree of functional incapacity due to psychological factors be recognized? How much fear and depression does the patient experience?

What has the central family member been told regarding the illness? Has different information been given to different people, and has the family been instructed or advised as to ways of dealing with the patient?

What is the family reaction to the illness? Will there be areas of difficulty or instability that should be supported or attended to?

What supplementary support does the physician regard as necessary to maintain the family?

These questions must be posed as questions needing discussion and not organized into a checklist. If given an opportunity, physicians will abbreviate discussion in areas of discomfort to the point of ritual. These questions are offered as a guideline that each physician will modify depending on personal style.

Well-documented information in the record serves as a means of communicating information about a patient. Appropriate therapeutic steps can be taken either to correct a psychological impression or to make decisions. These should be functions of every physician and should not be seen as areas of concern solely for a psychiatrist or a social worker. In accepting this responsibility, the physician should be in a better position to administer care and make judgments concerning patient and family.

Neurological Findings Following Short-Term Sleep Deprivation

Jon F. Sassin

I had the opportunity to perform serial neurological examinations on 11 subjects before and after they had been awake for 60 hours, and after recovery sleep.

The subjects were healthy Navy enlisted personnel, who had volunteered to participate in a study of the effects of sleep deprivation. They were assigned to one of three groups. After three baseline days including eight hours of undisturbed sleep each night, subjects in each group were kept awake throughout the next three days and two nights. All lost two consecutive night's sleep for 60 hours. One group (four subjects) was then allowed full recovery sleep; the second group (four subjects) was then further deprived of rapid eye movement (REM) sleep for two nights, then allowed full recovery sleep. The third group (three subjects) was deprived of sleep stages 3 and 4 and then allowed undisturbed recovery sleep.

The most consistent finding after 60 hours without sleep was a 20 to 40 percent loss of strength of flexion of the neck in nine subjects, irrespective of group, both by clinical and head halter measurements. Neck extension, side-to-side and rotatory movements were not affected and there was no loss of strength in axial or limb muscles. Tone was normal. The weakness of neck flexion was eliminated by eight hours of sleep in seven of the nine subjects regardless of type of sleep, and neck strength had recovered in all subjects after two nights of recovery sleep.

A fine, rapid regular tremor of outstretched fingers and hands developed in six subjects and disappeared after one recovery night. In another, abnormal movements of the outstretched fingers and hands were of larger amplitude, less regular, and more choreic in appearance.

Horizontal nystagmus on lateral gaze appeared in three subjects. Four showed clumsiness of fine movements of the fingers and rapid alternating movements of the fingers and hands. Ptosis of noticeable proportion occurred in two subjects. One subject was dysarthric. Another had two episodes of loss of equilibrium. Complaints of burning eyes with evidence of mild conjunctivitis were common. Visual acuity remained normal. Four subjects reported increased irritability of the soles of the feet when stimulated with a key or stroked by hand.

Changes in mental state were common although not so severe as those reported after long sleep deprivation. There was decreased attention span, apathetic appearance, and a preoccupation with details, especially those related to personal belongings.

Even though the mechanisms of these reversible abnormalities remain obscure, circumstances leading to disturbed sleep patterns should be considered in the evaluation of hospitalized patients and persons whose change in work habits or environment might lead to sleep deprivation.

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Apparent Movement of Sounds: Auditory Autokinesis

DAVID R. PERROTT and DAVID J. FRENCH

Autokinesis is a class of phenomena in which stationary objects are perceived as moving. Although the apparent movement phenomenon has been of interest to researchers since the late 1800s, its treatment was limited to visual autokinesis. Recently investigators have reported autokinesis in a free-field listening situation and autokinetic effects with tactile kinesthesis. Autokinesis appears to be a more general phenomenon than earlier research would indicate.

Many attempts to provide an adequate description of autokinesis reflect the emphasis on visual phenomena.

A more parsimonious approach would center on general features of the stimulus-organism interaction that are common to all modalities. Involuntary eye movement, for example, would produce a "real movement" of the visual image on the retina. The real-movement hypothesis can be tested in any modality where autokinesis is observed. Real movement is relatively easy to control with auditory stimuli. The basic cues for sound localization are the interaural differences of the signals at the ears. Diotic listening (an identical signal led to each ear) with earphones eliminates changes in interaural phase and intensity difference cues even with head movements. In a visual task, the effects of the visual frame of reference may be attributed to any of several potential mechanisms; the test situation itself precludes their separation. Since sounds can be localized without visual cues, the visual frame of reference can be manipulated independently of the auditory stimulus array to be localized.

The use of an auditory localization task to study autokinesis would seem to provide a more readily available research vehicle. This study was conducted to evaluate the effects of autokinesis on: involuntary movement, visual frame of reference, and stimulus complexity.

Twenty subjects, all experimentally naive, were employed. All exhibited normal hearing and the ability to localize a sound source.

Signals were led from a random-noise generator or an oscillator through attenuators and then to a loudspeaker or to two sides of a pair of earphones located in an audiometric cubicle where the subjects listened.

A hidden speaker was positioned 12 feet directly in front of the subject. Each subject was tested on four conditions, with the order of testing randomized: diotic presentation (via earphones) with no illumination of the cubicle, diotic presentation with the cubicle well illuminated, free-field presentation of the signal (via the hidden speaker) with no illumination, and free-field presentation with the cubicle illuminated.

Ten subjects received only a random noise signal set at 40 phones. The remaining 10 received a 1,000-Hz sine wave signal, set at 40 phones. Each condition lasted 5 minutes, with the audio signal remaining on for the entire five-minute period.

The subjects were instructed to press a response key as soon as movement was detected, and to hold the key down until the movement ended.

All subjects presented with the

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1,000-Hz signal reported movement of the sound source, whereas only eight subjects reported movement with the noise signal. Subjects reported movement more often to the 1,000-Hz sine-wave signal than to the noise. A significant interaction was obtained between the type of presentation and the duration of exposure to the signal. Subject presented with a 1,000-Hz signal via earphones showed a sharp increase in movement responses which was not evident in any other condition.

Mean movement duration was the same for both tone and noise, as well as for earphones and speakers. Significant changes in mean movement duration were observed between tone and noise and lights on and lights off.

Diotic presentation, in which maximum control of interaural stimulation can be maintained, produced strong auditory autokinetic effects; in fact, more movement was observed diotically than in the free-field listening situation, in which small head movement would be expected to produce changes in interaural stimulation.

No simple effect of visual frame of reference was indicated. Autokinesis was observed under all conditions.

Subjects, wearing earphones, reported that the tonal image was heard to move on the lateral dimension. Free-field listening resulted in apparent movement in three dimensions: right-left, up-down, and front-back. Observations with earphones produce a sound image that is perceived intercranially, and movement is perceived on a unidimensional lateral plane. Naive subjects were not likely to be aware of this fact, which seems to lend credence to their observations of movement.

No theoretical model for autokinesis is suggested at this time.

The Center for Studies of Schizophrenia

LOREN R. MOSHER

Schizophrenia remains the most challenging and devastating major mental illness. More than 200,000 Americans are hospitalized with this disorder. At least 2 percent of persons born in 1960 will have an episode of schizophrenia during their lives. Because of the magnitude of the problem and the need for a focal point within the National Institute of Mental Health, the Center for Studies of Schizophrenia was formed.

As a "coordinating center" within the Institute the Center does not conduct its own research programs, but operates across division lines to coordinate and stimulate programs in schizophrenia. The Clinical Research Branch (of which the Center is a part) in the Division of Extramural Research Programs reviews applications for grant support of clinical research relating to schizophrenia. The Applied Research Branch retains administrative responsibility for its programs relating to schizophrenia. Training grants are the responsibility of the Division of Manpower and Training Programs, while the Division of Mental Health Service Programs administers support programs for improving in-hospital treatment and staff training.

The Center's aims are to serve as a focal point for NIMH activities in schizophrenia, analyze and evaluate current research and related program developments, stimulate and develop programs of research, service, demonstration, and training pertaining to the psychological, social, and biological aspects, recommend the extent to which research and training grants, contracts and conferences should be used to develop and support these programs, collaborate with organizations outside the Institute to facilitate program development, and stimulate communication of information through consultation and development of conferences, committees, and publications.

A major initial goal of the Center is to facilitate communication. In February 1969 it sponsored a three-day workshop on current problems in research and training. Research developments were conveyed to professionals engaged in training, and new directions in training were discussed with those engaged in research. An additional goal was the stimulation of interest in schizophrenia as a clinical entity.

In formulating its programs, the Center conducted an intensive review and analysis of recent developments in Institute-supported activities in schizophrenia. Three areas were tentatively identified as meriting special attention: diagnosis, etiology and prevention, and treatment.

Diagnosis—A primary step in progress against any disorder rests on the ability to diagnose it reliably. The problem has been vexing in schizophrenia, where clinicians vary in their training and in the breadth of their concepts of what represents schizophrenia. We hope to encourage a focus on the descriptive dimensions of schizophrenia to obtain, where possible, a terminological consensus and to develop more meaningful subtypes than those so far identified. When agreement is not possible, we would like to be able to specify those aspects

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of the diagnostic process which are particularly difficult to rate reliably. In conjunction with the Psychopathology Section of the Clinical Research Branch, the Center is developing films and video tapes which can be used in delineating some of the dimensions of schizophrenia.

Etiology and prevention—Most clinical research focuses on the manifest and diagnosed schizophrenic. This approach has a major methodological problem: It is not possible unequivocally to determine the direction of causation for any differences found. The investigator cannot know whether his findings are the cause or the result of the schizophrenia. To stimulate work in this area the Center has contracted for a monograph to review the literature on children vulnerable to the development of psychopathology: it has sponsored a small workshop focusing on the methodological issues in such longitudinal prospective studies. If some of the technical difficulties can be overcome, they will provide more reliable evidence about the etiology of schizophrenia.

Treatment—The primary concern of the individual patient and his family is treatment. Great advances in treatment have resulted from the introduction of the psychopharmacological agents. Despite the control of the symptoms provided by tranquilizers, there are many patients who do not leave the hospital, and many who do leave are functionally impaired. Furthermore, there are a substantial number of patients who are not helped by drugs. Finally, the proliferation of community mental health centers will mean that many patients formerly hospitalized will be maintained in the community, where control of medication is more tenuous. These factors made systematic study of nonsomatic treatment especially important. Research findings will be used in the study of special milieus and groups, and in modifications of individual psychotherapy for the treatment of acute schizophrenia. Each modification will be studied as to its comparative efficacy, usefulness as adjunctive to drug treatment, and application in particular situations or types of patients. One development is the view of schizophrenia as a developmental crisis through which some individuals must be helped to attain higher subsequent levels of integration and functioning. This view could have important implications for treatment philosophies.

The Center will also press for changes in the existing institutional system and development of new types of facilities for treatment. It is important for treatment centers to be small enough, flexible enough, and have sufficient personnel to allow individualization of care. If the cost of schizophrenia to society is to be decreased, this problem must be given consideration.

In its ongoing critical overview of the field the Center will look for subareas that seem promising or underdeveloped, and in need of stimulation. Through conferences, workshops, and publications, the Center will provide a vehicle for the discussion, integration, and dissemination of findings reported by widely separated investigators. The Center will also provide information and/or consultation to individuals and institutions with regard to NIMH programs in schizophrenia, research strategies, and recent developments in the field.

Mental Health and the Law

Major Federal and State Narcotics Programs and Legislation

ROLAND W. WOOD

The following discussion is an attempt to consolidate descriptions of the programs that form the major treatment efforts for addicts.

Degree of control—The first generalization is that control—legal, social, or other—is necessary for the treatment of the addict.

More control than is necessary is nothing but punishment; less control than is necessary is poor treatment. Treatment and control are not incompatible. In the 10-point scale below, 1 to 5 refer to private agency programs; 6 to 10, to public agency programs:

1. Drug abuse is a problem in the medical profession. A study shows that addicted physicians are urged to get into private treatment and that 94 percent are returned to practice with little control other than revocation of their narcotic licenses and sanctions imposed by the American Medical Association.

2. There are housewives who take pills to get up in the morning and to go to sleep at night. Social control is exercised by the family.

3. Some addicts admit themselves voluntarily into U. S. Public Health Service facilities or other treatment settings, and have the internal control necessary to remain in treatment.

4. Organizations such as Synanon and Teen Challenge apply social controls to persons who volunteer for treatment and who would abandon treatment if these controls were not provided.

5. Some persons, lacking the internal controls to stay in a voluntary treatment facility, leave it against medical advice.

6. At this point, where a patient who had previously been in voluntary treatment resumes drug injection to relieve his anxiety, the process starts all over again, with the external legal control being exercised by a public agency to get the addict into treatment and keep him in treatment.

7. The next level at which treatment can be made available is probation and jail.

8. A straight jail term is next. As a solution, it is meaningless unless a constructive treatment program is part of the term and aftercare is provided.

9. Compulsory civil commitment.

10. Prison, especially for the aggressive, criminally oriented offender.

Private or public agency client?—The second generalization is that it will always be the public agency's job to deal with the kind of client whom the private agency will not or cannot deal with.

To get into any public institution you must annoy someone; steal, write bad checks, cause a disturbance, or be a general nuisance. Often we commit people to public programs when we are angry rather than concerned.

Legal framework—The third generalization is that from the clinical standpoint, the present legal framework appears to be unrealistic.

The person repeatedly involved in drug offenses represents a challenge to the new organizational forms being developed for treatment. Typically, he will choose a short jail term rather than a longer term of compulsory treatment. He is reluctant to volunteer for treatment and, if he does, is not likely to stay.

The predominant method has been to place the addict in the county jail for a short period of time. Generally drug use resumes following release.

Condensed with permission from *Crime and Delinquency*, 16(1):36–56, 1970.

We do not have effective treatment resources for this kind of addict. Many programs exclude such persons even though their criminal involvement is related to their addiction. They are excluded because the client does not fit the mold of present treatment alternatives.

Without such treatment resources the cost to the community will continue at staggering levels. It is the addict who becomes a threat or economic burden that the legislature is most interested in getting into a public treatment program.

Throughout the country interest has been shown in civil commitment as a more effective method of working with the addict. While civil commitment is being questioned in regard to civil liberties and guarantees of due process of law, it offers the possibility of a legal and organizational "third alternative" for the treatment and control of addiction.

There are different kinds of addicts, needing different kinds of treatment and different amounts of control. The addict should enter the program that offers the necessary amount of control. External control, compensating for the client's lack of internal controls, is relaxed as his internal controls begin to strengthen. Applying more controls than is necessary reaches into the realm of punishment. The practical administration of treatment and control must leave room for more discretion by judges and public agency officials. The enactment of rigid minimum and maximum terms does not allow this development.

Federal Treatment Programs

The Federal Narcotic Addict Rehabilitation Act of 1966 enables States and communities to assume responsibility for addicts.

Under the Act, an eligible person charged with a crime may be advised by the court that the criminal charge will be held in abeyance if he elects to submit to a medical examination to determine whether he is an addict and is likely to be rehabilitated through treatment. The defendant has five days to make his decision. If he accepts, he may be detained for no more than sixty days for examination purposes. He also consents to civil commitment if he is found to be a suitable candidate for treatment. Commitment is to the Surgeon General for a maximum of three years. If the treatment is successful, the criminal charge is dismissed; if, after thirty-six months, it is not successful, prosecution on the criminal charge is resumed.

The institution phase of treatment is limited to a two-year maximum unless the commitment is re-affixed by the court. If, after release to aftercare, the outpatient should relapse, the court may return him for treatment or resume the criminal proceedings. Should he then be sentenced, any time served in the treatment program must be credited toward his time served under criminal sentence.

Sentencing procedures—If the court believes an eligible convicted offender is an addict, it may order him to be examined and then commit him to the custody of the Attorney General for an indeterminate period not to exceed ten years. The addict must spend a minimum of six months as an inpatient; he will be under the jurisdiction of and be released by the Board of Parole, except that the Attorney General may contract with public or private agencies for aftercare treatment. The Board of Parole handles returns for additional treat-

ment, and the Act provides that the Board of Parole shall handle the release and re-admission of addicts brought to the attention of the court on a criminal charge.

Persons may volunteer for treatment or be referred by a "related individual" through the filing of a petition with the Federal district attorney, who may then order the alleged addict to appear for court examination. At commitment the process ceases to be voluntary. The term of commitment may not exceed three and one-half years, but no mandatory minimum period of stay is required. Presumably this would allow some addicts to enter directly into outpatient programs.

Difficulties with the Act—The exclusionary criteria may be too stringent for commitment under Titles 1 and 2 of the Act. Assault with a dangerous weapon or with intent to commit any offense punishable by imprisonment for more than a year is reason for exclusion. Other persons declared ineligible are those who have been convicted of burglary or housebreaking at night, or have been convicted of a felony on two or more prior occasions, or have been civilly committed under the Narcotic Addict Rehabilitation Act of 1966 or any State proceeding involving civil addict commitment on three or more occasions.

Burglary is a common addict offense; the States disagree on what constitutes a felony; exclusion after repeated attempts at treatment rules out involvement in future treatment programs, throughout the country.

Unless he is sentenced to the Federal program, the addict must elect treatment. The election clause may cause the program to recruit addicts who are involved in criminality, instead of carrying out the legislative intent: nonpunitive but compulsory treatment for the person who is primarily an addict and secondarily involved in crime.

The criminal proceeding may be suspended at any point. This raises two questions: If the criminal proceeding is suspended before conviction is there any basis upon which "volunteer" and criminal commitments can be treated differently? If the criminal proceeding is suspended before conviction and the addict is later found to be unsuitable for volunteer treatment, can the relevant evidence and witnesses be recalled to continue the proceeding?

Evaluation—The Act authorizes assistance to States and localities to develop their programs and gives the Surgeon General authority to contract for the care and treatment of addicts in facilities close to their homes. Guidelines and regulations are being developed.

Though the legislation is potentially a contribution to solution of the problem, the funds provided to date do not support it.

Federal hospitals—U. S. Public Health Service hospitals were established at Lexington and Fort Worth in 1935 and 1938 primarily for Federal prisoners.

Voluntary patients, admitted as space becomes available, make up about half the population of the hospitals at any one time.

The regime consists of withdrawal treatment, psychiatric evaluation, and a range of services. Most voluntary patients have left against medical advice. There is no effective aftercare program except when the prisoner-patient is granted parole.

Under the provisions of the Narcotic Addict Rehabilitation Act of

1966, the role of these hospitals is changing to clinical research. The two centers will be used for inpatient and diagnostic treatment services during the transition period, but, as local programs develop, voluntary admissions and admission of prisoners will be restricted. Eventually only addicts needed to conduct research will be admitted. The hope is that all other addicts will be in local programs.

The States

The next sections review developments in New York, California, New Jersey, and Illinois, the locales of some of the largest narcotic treatment control efforts.

New York

New York State has embarked upon the most comprehensive addiction-treatment program ever attempted.

In 1956, in response to the increase in the number of parolees with a history of opiate addiction, the State initiated a Special Narcotic Project. The project is a landmark in the use of authoritative casework supervision and serves as a model for specialized parolee programs.

The Metcalf-Volker Act, passed in 1962, placed responsibility for the care of arrested addicts with the State's Mental Hygiene Department's hospitals. Hospitalization was not to exceed three years. When charged with a drug or non-drug crime, an addict would *elect* treatment; the criminal matter was stayed. Medical personnel made release decisions for the aftercare program.

If an addict had a prior felony pending or two prior felony convictions, or if he possessed large quantities of drugs, he could not be referred for civil commitment.

Though hailed as a new approach, the concept of civil commitment produced disturbing results, which were attributable partly to the law itself but largely to insufficient funding, a lack of facilities, and a shortage of properly trained personnel.

The majority of arrested and eligible addicts did not elect commitment but preferred the criminal process. About half who did elect treatment were rejected by the Department of Mental Hygiene.

Nevertheless, this experience provided building blocks for the most recent step in New York. 1966 legislation amended the Mental Hygiene Law and established a comprehensive program for the treatment, rehabilitation, and aftercare of narcotic addicts. The program is carried out by the Narcotic Addiction Control Commission, which has been given sweeping administrative powers to embrace all possible aspects of treatment, control, prevention and research.

The three major goals are to provide *care* for people who are afflicted; opportunities for such persons to move in the direction of *cure;* and to *control* those who are sent to the Commission for care.

California

California's approach to narcotic treatment is separated into a number of interlocking programs, all under the administration of the Director of Corrections in the Human Relations Agency.

In 1959, a Narcotic Treatment Control Project was established for the treatment and control of felon parolees with a history of opiate use. The approach was similar to the New York State Project in that it stressed supervision of parolees.

California has developed a test system emphasizing Nalline, a synthetic opiate anti-narcotic; urinalysis; and skin check for needle marks. The tests are administered by physicians. The testing program is linked to small specialized caseloads enabling agents to be more aware of behavior that accompanies relapse.

The Civil Addict Program, established in 1961, provides compulsory inpatient and aftercare treatment and control for opiate users.

Addicts are civilly committed by the Superior Court. The proceedings under which the addict may be committed may be initiated in three ways:

The addict, a relative, or other responsible person may approach the county district attorney, who may then petition the court for consideration of the addict's commitment. No criminal charge is involved.

If any person is convicted of any crime in a municipal or justice court and is believed by the judge to be an addict, the proceedings shall be adjourned or the judge may suspend the imposition of sentence.

Any person convicted of a felony (with certain exclusions for aggressive offenses) may, if the judge believes he is an addict, be referred to another Superior Court to determine his addiction after he is convicted and the original criminal proceedings are suspended.

The commitment proceedings are essentially those used for commitment of the mentally ill. Once he is committed, the addict is bound for a definite period even though he may have initially volunteered for treatment.

The law provides a maximum of a two and one-half year commitment for volunteers and a seven-year commitment for others. This term includes both inpatient care and aftercare.

The law requires a minimum of six months' inpatient treatment on an original commitment but sets no limit on length of stay for a returnee.

The California effort includes private and governmental local programs and, at the State level, the California Rehabilitation Center and special parole programs. Addicts ineligible for civil commitment are committed to a State prison.

New Jersey

A mental hygiene model, influenced by members of the medical profession, was enacted in New Jersey in 1964. Originally it was under the jurisdiction of the Commissioner of the Department of Institutions and Agencies and was located in the Division of Mental Health and Hospitals.

In 1967 a Bureau of Narcotic Addiction and Drug Abuse was established within the Division to carry out the Department's responsibilities.

Civil commitment has been considered; however, the consensus has been to await evaluation of the civil commitment approaches of California and New York and the provisions of the Federal Narcotic Addict Rehabilitation Act of 1966.

The value of the New Jersey plan is that its newer, basically mental hygiene approach offers a working alternative to civil commitment.

Most persons committed for treatment have been sentenced under the Narcotic Act or Dangerous Drug Act, which provides that persons using drugs illegally are disorderly persons.

The judge, when sentencing for disorderly conduct, is required to give the person the option of serving his time or volunteering for treatment.

If the defendant chooses the latter, the sentence is suspended and he is placed on probation for up to three years; if he chooses the former, the length of sentence is one year.

A person 21 years old or more or a married person under 21 may voluntarily admit himself for a minimum of 45 days. Persons under 21 and unmarried may be admitted by a parent or guardian.

Persons who have been convicted of use of narcotics and dangerous drugs and are serving sentences may apply for re-sentencing and may request admission to inpatient treatment for narcotic addiction.

Persons awaiting trial may seek treatment if they are found to be suitable candidates by the receiving hospital and the sending facility.

All patients with suspended sentences are required to attend the aftercare clinic (where one exists). Voluntary patients are encouraged to attend.

Illinois

The only real addiction facility in Illinois until 1968 was in the House of Correction in Chicago. In 1965 the General Assembly created the Narcotic Advisory Council in the Department of Mental Health. The purpose was to recommend programs for the prevention of addiction and the treatment and rehabilitation of addicts. In 1967, the legislature passed the Drug Addiction Act, which puts all concepts of treatment under one umbrella. The Drug Abuse Program began in January 1968 with three employees and no patients.

The Council recommended the development of a pilot program focused on an area in Chicago with a high prevalence of narcotic use. The word "pilot" implied that the structure should be flexible enough to disassemble entirely should none of the activities prove helpful but sturdy enough to provide a framework on which a State program could be built if it indeed proved valuable.

By February 1, 1969, the following program elements were operational: intake, pre-treatment, inpatient treatment, methadone support, group therapy, aftercare, cyclazocine, therapeutic communities, research, and evaluation.

The funding necessary to support this type of program may be a problem. More experience will be needed with this "pilot" program before any generalization can be made.

Innovative programs and public policy have reversed the punitive trends in the control and treatment of the addict. It is obvious that a full spectrum of services and resources will be required if we are ultimately to bring narcotic addiction under control.

Mental Health News Digests

Hospital & Community Psychiatry Service

The Hospital & Community Psychiatry Service of the American Psychiatric Association helps organizations serving the mentally ill and mentally retarded. Any organization concerned with mental illness or mental retardation may become a member of the service.

The service includes consultation and information, answering a wide range of questions on such topics as standards of practice, program development, staff development, manpower utilization, architecture, administration, sources of special information, location of innovative programs, and specialized resources.

Members receive a monthly publication, *Hospital & Community Psychiatry*, a professional journal concerned with administration and treatment programs in the whole range of psychiatric resources.

Supplementary mailings, ordinarily monthly, include such materials as reports of clinical research, mental health fact sheets, special authoritative bibliographies, and compilations of information of interest to administrators and clinicians. Special books or reprints are available. A film service makes available on loan about 60 16-mm movies selected for their value in staff education, inservice training, and community education.

The service sponsors an Annual Institute on Hospital & Community Psychiatry, an interdisciplinary forum open to staff members of psychiatric and related health and educational facilities. At the Institutes, the service presents annual achievement awards for outstanding treatment, research, or administrative programs.

Inquiries concerning the service may be addressed to Donald W. Hammersley, M.D., Chief of Professional Services, American Psychiatric Association, 1700 Eighteenth St. N.W., Washington, D.C. 20009.

News from the World Psychiatric Association

The November meeting of the Executive Committee in London was devoted to planning the Fifth World Congress of Psychiatry to be held in Mexico City on November 28–December 4, 1971. The following topics were chosen for the plenary sessions: Drug Taking and Adolescence; Geriatric Psychiatry; Family Psychiatry; Psychiatric Education; Psychopharmacology; Role of the Psychiatrist Today; Ecology and Psychiatry; Rehabilitation in Psychiatry; Biochemical Correlates of Psychiatric Illness; The Psychopath; The Work of WHO in Psychiatry.

A symposium, in conjunction with the Academy of Medical Sciences of the U.S.S.R., will be held in Tbilisi, Georgia, U.S.S.R. in September 1970. The topic of Schizophrenia will be discussed under the following headings: the clinical state and epidemiology of schizophrenia; the clinical course, treatment, and prognosis of schizophrenia; the genetic and biological aspects of schizophrenia; and the psychopathological aspects of schizophrenia.

Mental Health Training for Practical Nurses

The State of Pennsylvania now has a program under which licensed practical nurses receive specialized training in the care and treatment of the mentally disabled. The program will

stress development of a better understanding of the needs of the mentally disabled and their families, as well as a broader understanding of the hospital, county, State, and Federal resources for the prevention and treatment of mental disabilities. The nurses' role in the therapeutic nursing care of individual patients also will be emphasized. Upon successful completion of the program the nurses, in addition to caring for physically ill, disabled, or bedridden patients, will assume a more active role as members of the patient care team providing services to the mentally disabled. Guidelines for the program were prepared by a staff development committee with membership representing the nursing staff of the State-operated facilities for the care and treatment of the mentally disabled.

The Right to Abortion: A Psychiatric View

"Abortion when performed by a licensed physician should be entirely removed from the domain of criminal law." This is one conclusion of the Group for the Advancement of Psychiatry in a report, *The Right to Abortion: A Psychiatric View*. Formulated by the Committee on Psychiatry and Law, the report analyzes the question of legalized abortion from social, ethical, and legal points of view. It concludes ". . . that a woman should have the right to abort or not, just as she has a right to marry or not." Anything short of this ". . . stand[s] foursquare against the right of the woman to control her own reproductive life."

The authors feel that the moral questions of when life begins and what constitutes the taking of life in this situation are answerable only through personal religious beliefs and should not be directed by the State. The report points out that opinions of both the Roman Catholic Church and English law on this subject have altered. Today's society is still uncertain. "Were our society convinced that abortion is murder, it would exact the same penalty against abortionists as is levied against other parties to premeditated murder—life imprisonment or even capital punishment. Of course our society does no such thing."

This same uncertainty is reinforced by the use of several methods of birth control. The function of some of ". . . the chemical and mechanical means of birth control is probably to interrupt the pregnancy *after* conception has taken place. In so doing, these contraceptives have made it all the more difficult to delineate contraception from abortion."

Present laws, it is emphasized, do not eliminate illegal abortion. The affluent do not find it difficult to obtain a "therapeutic" abortion, while others ". . . are driven . . . into the hands of practitioners and charlatans who may employ dangerous techniques." Seeing the moral issue as a "seemingly insoluble" legislative problem, the authors express repeated concern for the mental health of both mother and child. "There can be nothing more destructive to a child's spirit than being unwanted, and there are few things more disruptive to a woman's spirit than being forced without love or need into motherhood."

The report criticizes the American Law Institute's "liberalized" abortion law. This law provides for a legal abortion when great risk to the mother's physical or mental health is ap-

parent, or when conditions indicate that the child would be born with grave physical or mental handicap. Such beliefs must be certified by two physicians in writing. The authors argue that this law does not provide any answer to the moral question. Neither does it provide specific psychiatric criteria for standardizing interpretation of the law in all States. Decisions fall upon the psychiatrists instead of upon the individual or upon society. "If society wants abortion to be easier, it should have the courage to campaign for it honestly and not exploit the psychiatrist." The law also calls for a "public confession," eliminating the confidential nature of the doctor-patient relationship.

In conclusion, the authors recommend further study of the problem leading to future policy changes.

Copies of the report (GAP Publication No. 75) may be obtained for $1.00 from the Publications Office, Group for the Advancement of Psychiatry, 419 Park Ave. South, New York, N.Y. 10016.

Mental Health Training Methodology Bibliographies

Three annotated mental health training methodology bibliographies have been prepared jointly by the National Communicable Diseases Center and the National Institute of Mental Health:

Inservice Training for Key Professionals in Community Mental Health (PHS Publication No. 1900, 60¢) contains 189 annotations.

Inservice Training for Allied Professionals and Nonprofessionals in Community Mental Health (PHS Publication No. 1901, 55¢) contains 169 annotations.

Inservice Training in Mental Health for Staff in Residential Institutions (PHS Publication No. 1902, 35¢) contains 86 annotations.

All may be ordered from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

Standards for Psychiatric Facilities

The American Psychiatric Association has recently published a 115-page booklet, *Standards for Psychiatric Facilities.* Included are 45 standards, 13 relating to diagnosis and treatment; 30 to organization and personnel; one to physical plant; and one, applicable only to general hospitals, concerns reception, management, and disposition of psychiatric patients.

The psychiatric facilities to which the standards are applicable are community mental health centers, psychiatric outpatient clinics, psychiatric services in general hospitals, private psychiatric hospitals, public psychiatric hospitals, and services for the mentally retarded.

The standards are based on ten principles:

The primary functions of any psychiatric facility are to diagnose, to treat, and to restore mentally disordered persons to an optimal level of functioning and return [them] to the community.

The psychiatric facility acknowledges the dignity and protects the rights of all its patients.

The psychiatric facility has an ethical, competent staff.

The psychiatric facility integrates its services with other community resources and is responsive to community needs.

The psychiatric facility cooperates with standard-setting and reimbursement requirements of various third-party payors in order to provide for its patients the economic protection of health insurance.

The psychiatric facility keeps accurate, current, and complete clinical and administrative records.

The psychiatric facility has written policies, procedures, and plans.

The physical plant of the psychiatric facility provides a safe, wholesome environment that enhances the program.

The psychiatric facility is available, accessible, and appropriate for the care of all potential patients.

The psychiatric facility promotes a climate that makes possible the establishment of significant relationships between staff, patients, and their families.

In addition to the standards, the booklet describes desirable methods of organization and operation for the various types of psychiatric facilities. It also contains data on standards for psychiatric facilities collected from 42 States, the APA position statement on the question of adequacy of treatment, a list of institutions that have training programs in administrative psychiatry, sources of information used in formulating the standards, and a list of accrediting agencies and professional organizations.

Staff of the Mental Health Center

The *Staff of the Mental Health Center: A Field Study* is a recent publication of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health. Written by Raymond M. Glasscote and Jon E. Gudeman in collaboration with six consultants, it reports the findings of a study of several hundred employees on the staffs of eight community mental health centers in various parts of the country. The authors and consultants interviewed the personnel of these centers to determine the extent and nature of their training, their theoretical persuasions about treating the mentally ill, their morale, their principal satisfactions and dissatisfactions, their personal priorities for mental health services, and other matters pertinent to staffing of community based facilities.

Copies are available for $6.00 from the American Psychiatric Association, 1700 Eighteenth St. N.W., Washington, D.C. 20009.

State Action in Mental Health, Mental Retardation, and Related Areas

This publication is concerned with the results of surveys of State programs in 1965 and 1967, and includes administrative, legal, and financial information. *Action in the States in the Fields of Mental Health, Mental Retardation, and Related Areas* may be obtained for $5.00 from the Interstate Clearing House on Mental Health, 1313 East 60th St., Chicago, Ill. 61637.

recent nimh publications

Single copies of these publications may be obtained from the Office of Communications, National Institute of Mental Health, LL02, 5454 Wisconsin Ave., Chevy Chase, Maryland 20015. A complete list of all publications available from the NIMH may also be obtained from the Office of Communications. If a price is given, the publication may be ordered in quantity from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Enclose a check or money order payable to the Superintendent of Documents.

A Statistical Information System for Community Mental Health Centers. This 57-page report is based on a workshop on statistics systems for multiservice local mental health programs held in Athens, Georgia, under the sponsorship of the Southern Regional Conference on Mental Health Statistics. Prepared by Philip H. Person, Jr., Biometry Branch, Office of Program Planning and Evaluation, NIMH. Public Health Service Publication No. 1863. 70¢.

Patients in Public Institutions for the Mentally Retarded, 1967. This is a 75-page report based on the 42nd Annual Census of Patients in Mental Institutions. Prepared by the Biometry Branch, Office of Program Planning and Evaluation, NIMH (text by Carl A. Taube). Public Health Service Publication No. 1860. 70¢.

General Hospital Inpatient Psychiatric Services, 1967. The data in this 122-page report are based on three surveys: one by the American Hospital Association, the second from data obtained from the annual Inventory of Mental Health Facilities; and the 42nd Annual Census of Patients in Mental Institutions. Prepared by the Biometry Branch, Office of Program Planning and Evaluation, NIMH (text by Carl A. Taube). Public Health Service Publication No. 1977. $1.25.

Outpatient Psychiatric Services, 1967. This is a 162-page report based on data obtained from the annual Census of the Terminations from Outpatient Clinics and the Inventory of Mental Health Facilities. Prepared by the Biometry Branch, Office of Program Planning and Evaluation, NIMH (text by Carl A. Taube). Public Health Service Publication No. 1982. $1.25.

Bulletin of Suicidology, March 1969. Previous issues of the *Bulletin* have appeared in July and December 1967 and July and December 1968. 65¢.

Suicide Among Youth (A Supplement to the Bulletin of Suicidology). This is a 64-page review of the literature for 1900–1967 prepared for the Joint Commission on Mental Health of Children by Richard H. Seiden, University of California at Berkeley. Public Health Service Publication No. 1971. 65¢.

Schizophrenia Bulletin, December 1969. This is the first experimental issue of a new publication. 50¢.

Psychopharmacology Bulletin, Vol. 5, No. 3, July 1969. Prepared by the Psychopharmacology Research Branch, Division of Extramural Research Programs, NIMH.

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